Critical Care Networks- National Nurse Leads

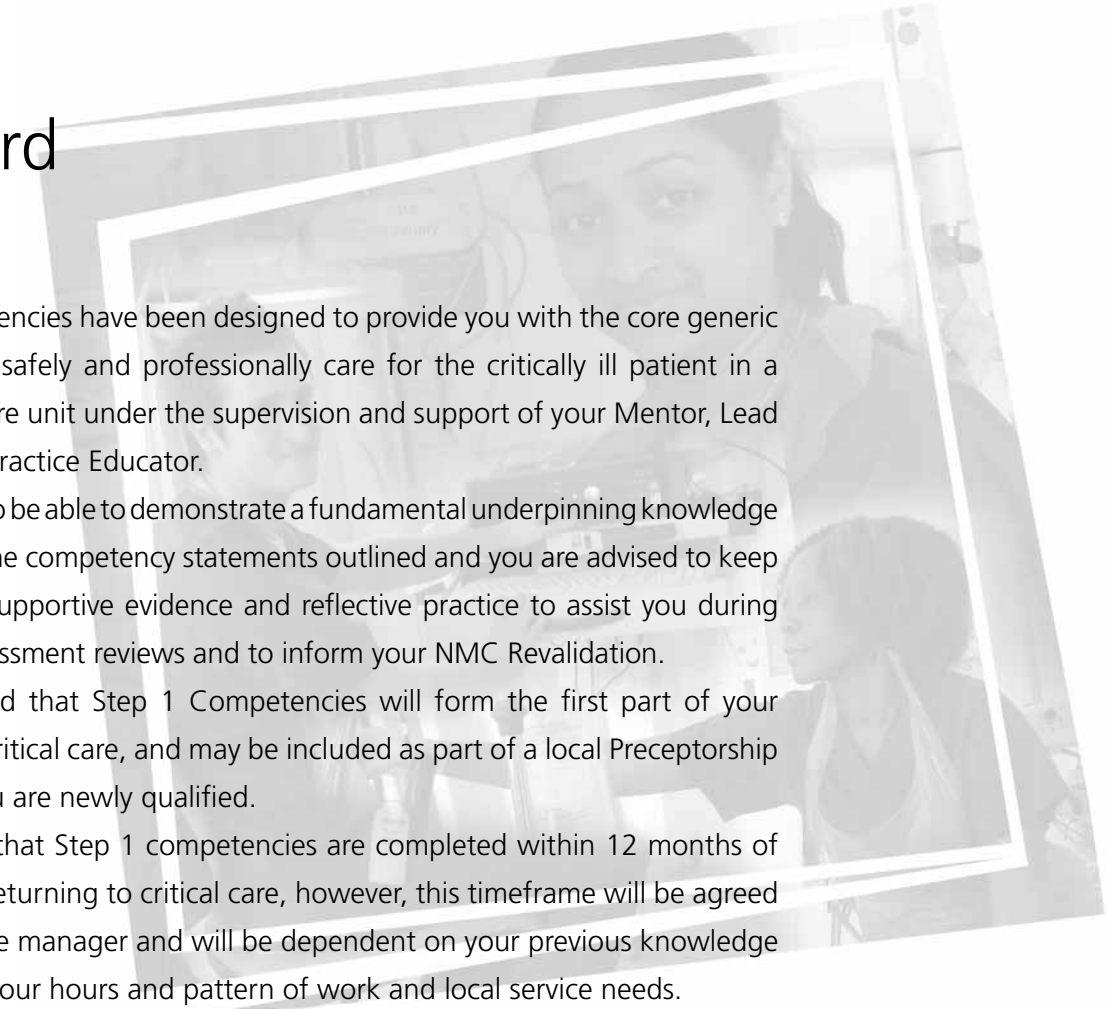
National Competency Framework for
Registered Nurses
in Adult Critical Care

Step 1

Step 1 Competencies

Version 2 : 2015

Foreword



All step 1 competencies have been designed to provide you with the core generic skills required to safely and professionally care for the critically ill patient in a general critical care unit under the supervision and support of your Mentor, Lead Assessor and/or Practice Educator.

You will need to be able to demonstrate a fundamental underpinning knowledge in relation to all the competency statements outlined and you are advised to keep a record of any supportive evidence and reflective practice to assist you during progress and assessment reviews and to inform your NMC Revalidation.

It is anticipated that Step 1 Competencies will form the first part of your development in critical care, and may be included as part of a local Preceptorship programme if you are newly qualified.

It is expected that Step 1 competencies are completed within 12 months of appointment or returning to critical care, however, this timeframe will be agreed locally by your line manager and will be dependent on your previous knowledge and experience, your hours and pattern of work and local service needs.

You will receive a supernumerary period when joining or returning to the critical care team, this will be agreed locally depending on your circumstances, however all newly registered nurses will need a minimum of 6 weeks. The shaded competencies have been identified for completion within your supernumerary period.

On starting your critical care development you will be required to complete a Learning Contract with your Lead Assessor and Unit Manager, this will provide the foundations for your individual commitment to learning, your assessors' commitment to the supervision and support you will require and your managers' commitment to providing designated time and opportunities to learn.

Competence is defined throughout this document as:

> *'The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective critical care nursing care and interventions'*

Learner Name PRINT	SIGNATURE
Lead Assesor/Mentor Name PRINT	SIGNATURE

Contents

Introduction: Outcome competencies adult critical care nurses

Who are these competencies for?

These competencies are designed for use by registered nurses embarking on a career working in a Level 3 critical care area. Critical care nurses play a pivotal role in the assessment, care and recovery of those patients who experience critical illness. Their experience, competence and knowledge allow them to work both on their own and in partnership with wider multidisciplinary healthcare teams.

Critical care nurses use a range of skills, including:

- Assessing the complex patient
- Interventional application
- Rehabilitation and recovery planning
- Information and knowledge management
- Leadership and risk management
- Decision making
- Communicating
- Influencing and negotiating
- Engagement and facilitation

Nurses are required to provide safe, high quality services for the public, and support improvements in the critical care environment so that the safety and quality of care is continually enhanced. The critical care environment is a constantly changing field with emerging technologies and therapies to aid patient recovery through the often life-threatening illness. Nurses need to ensure they develop and maintain competence in practice to meet the challenges presented.

How can I develop competence in critical care?

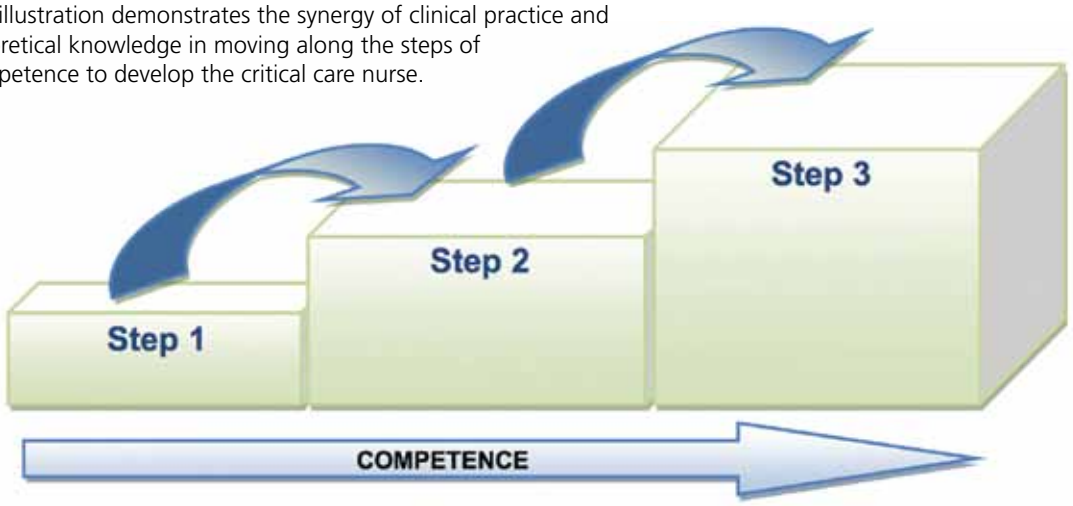
You can use these competencies to inform your development. You might already be close to achieving all of these competencies, or might be a long way off and have a lot of development to undertake depending on your previous experience. The thought processes you need to go through and the actions you need to take will be similar, the difference will be in the amount of experience that is needed and the level of knowledge required in supporting further development along the steps of competence. These competencies describe what it is that an individual is expected and able to do when they are fully functioning as a competent safe practitioner.

How the competency framework fits together:

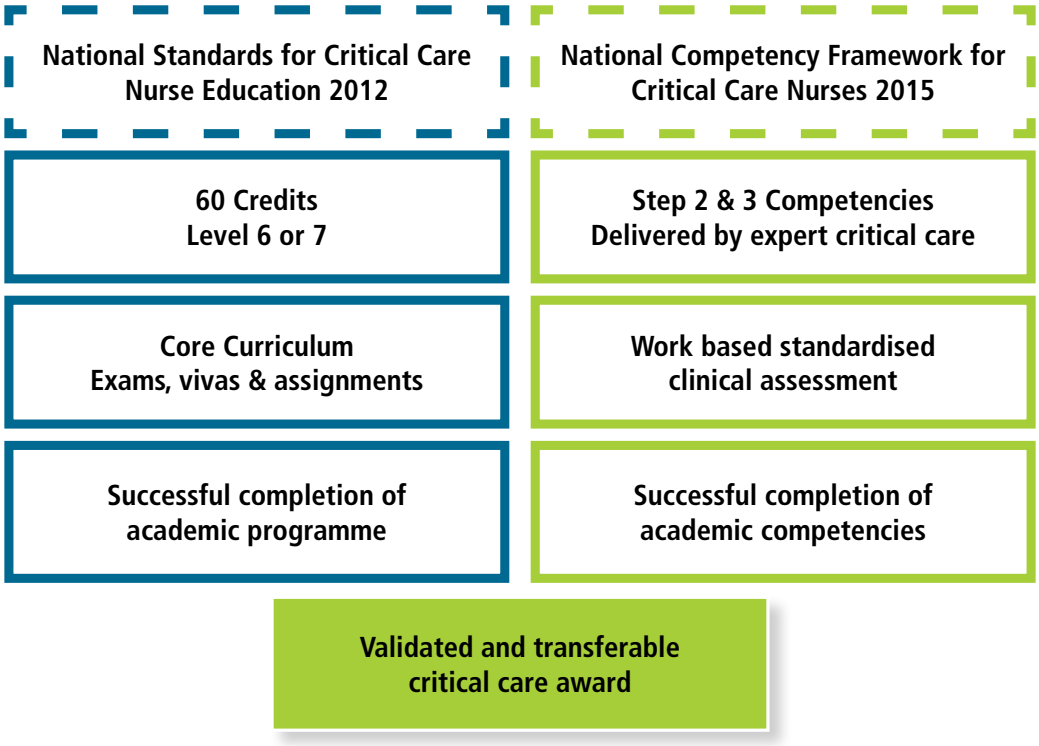
The competency framework is divided into 3 sections titled, Step 1, Step 2 and Step 3.

Step 1 has been designed to support the new starter and provides the foundation to critical care nurse competency development in practice. It is delivered locally before accessing higher education. Competency development starts immediately when the nurse is exposed to the unique environment of critical care, a setting that cares for the most vulnerable of critically ill patients; Areas of Step 1 Competencies have been shaded and italicised to indicate they need completeing first during your supernumerary period, however it is recognises that competency in practice depends upon a number of factors including exposure to a range of experiences and opportunities to attain, develop and apply related theoretical knowledge.

The illustration demonstrates the synergy of clinical practice and theoretical knowledge in moving along the steps of competence to develop the critical care nurse.



Step 2 & Step 3 have been designed to accompany post registration academic programmes where 'the learner' will gain the necessary depth of related theory and knowledge.



Step 2 competencies will allow the nurse to:

- Demonstrate skilled performance in the activity with enhanced theoretical knowledge and understanding giving rationale for practice
- Demonstrate application of knowledge and understanding in relation to relevant policies, procedures and guidelines
- Participate in problem solving through critical analysis and evaluation of more complex situations
- Develop more varied critical care experience with minimum supervision and guidance, attaining competence in related knowledge and skills

Step 3 competencies will allow the nurse to:

- Demonstrate competent performance in all the activities specified without direct supervision based upon relevant evidenced based knowledge, intuition and established practice
- Independently problem solve complex situations and offer solutions through critical analysis and evaluation
- Supervise and instruct others in a range of activities related to their role and responsibilities
- Apply knowledge, understanding and research to relevant policies, procedures and guidelines to critically analyse and improve practice

How will I be assessed?

Registered nurses aiming to achieve competence through all the 'Steps' will be supported in the clinical area by the local Practice Educator/Lead Assessor or equivalent and suitably experienced competent colleagues and mentors. You will be allocated a Lead Assessor who will oversee your ongoing development, colleagues and mentors will assist you in achieving competence in practice. The use of Assessment and Development Plans will enable you, mentors, Lead Assessors and Practice Educators (or equivalent) to monitor your development needs and overall competence progression. Adequate time and supervision will be given to you as you progress through the 'steps' and local areas may need to facilitate placements outside of the normal working environment if exposure to certain subject areas or treatments are limited. When assessing a critical care nurse against the clinical standard required, the sign off mentor or assessor is asked to specifying if the individual nurse can demonstrate competence in relation to each statement outlined within the document.

Competence must be demonstrated through **observation** of your practice against the competency statements outlined. Your mentor or Lead assessor may however use a combination of the following techniques to support their decision:

- Discussion & probing questions
- Simulation
- Completion of associated workbooks
- Reflective practice
- Portfolio
- Record of achievements

Resolving competency issues:

It is your responsibility to work in collaboration with your Lead Assessor and/or Practice Educator to discuss and agree your developmental needs in order to achieve competence in critical care practice. By following these simple rules it is hoped you will have a positive experience whilst developing yourself through the 'Steps of Competence':

- Have regular meetings with your Lead Assessor (at least 3 monthly) to assess your current level of competence and set a development plan for your progression
- Be realistic and not over ambitious
- Do not sign the Assessment and Development Plan if you are not happy with its contents
- Bring failure of mentorship in practice and/or ineffective assessor reviews to the attention of the Unit Manager at the earliest opportunity

Learning Contract

The following Learning Contract applies to the Individual Learner, Lead Assessor/Mentor and Unit Manager/Lead Nurse and should be completed before embarking on this competency development programme.
It will provide the foundations for:

- Individual commitment to learning
- Commitment to continuing supervision and support
- Provision of time and opportunities to learn

LEARNERS RESPONSIBILITIES

As a learner I intend to:

- Take responsibility for my own development
- Successfully complete a period of induction/preceptorship as locally agreed
- Form a productive working relationship with mentors and assessors
- Deliver effective communication processes with patients and relatives, during clinical practice
- Listen to colleagues, mentors and assessors advice and utilise coaching opportunities
- Use constructive feedback positively to inform my learning
- Meet with my Lead Assessor/Mentor at least 3 monthly
- Adopt a number of learning strategies to assist in my development
- Put myself forward for learning opportunities as they arise
- *Complete elements shaded and italicised as priority and within the allocated supernumerary period*
- Complete all Step 1 competencies in the agreed time frame
- Use this competency development programme to inform my annual appraisal, development needs and NMC Revalidation
- Report lack of mentorship/supervision or support directly to the Lead Assessor/Mentor, and escalate to the Clinical Educator/Unit Manager or equivalent if not resolved.
- ***Elements shaded grey and italicised only apply to specific centres.***

Learner Name (Print) .....

Signature ..... Date: .....

LEAD ASSESSOR RESPONSIBILITIES

As a Lead Assessor I intend to:

- Meet the standards of regularity bodies (NMC, 2008)
- Demonstrate on-going professional development/competence within critical care
- Promote a positive learning environment
- Support the learner to expand their knowledge and understanding
- Highlight learning opportunities
- Set realistic and achievable action plans
- Complete assessments within the recommended timeframe
- Bring to the attention of the HEI, Education Lead and/or Manager concerns related to the individual nurses learning and development
- Plan a series of learning experiences that will meet the individuals defined learning needs
- Prioritise work to accommodate support of learners within their practice roles
- Provide feedback about the effectiveness of learning and assessment in practice

Lead Assessor Name (Print) .....

Signature ..... Date: .....

CRITICAL CARE LEAD NURSE/MANAGER

As a critical care service provider I intend to:

- Facilitate a minimum of 40% of learners' clinical practice hours with their mentor/assessor and/or Practice Educator or delegated appropriate other within the multidisciplinary team
- Provide and/or support clinical placements to facilitate the learners' development and achievement of the core competency requirements
- Regulate and quality assure systems for mentorship and standardisation of assessment to ensure validity and transferability of the nurses' competence

Lead Nurse/Manager Name (Print) .....

Signature ..... Date: .....

Authorised Signature Record

To be completed by any Lead Assessor/Mentor or Practice Educator.

Print Name	Sample Signature	Designation	PIN	Organisation

Step 1: Tracker Sheet

The following table allows the tracking of Step 1 Competencies and should be completed by Lead Assessors/Mentors and/or Practice Educators (or equivalent) as the individual achieves each competency statement. This provides an easy and clear system to review and/or audit progress at a glance.

Competency Statement	Date Achieved	Mentor/Assessors Signature
Supernumerary competencies succesfully obtained and completed		
1.1 Promoting a positive patient experience		
1.1.1 Promoting psychosocial wellbeing		
1.1.2 Visiting in Critical Care		
1.2 Respiratory System		
1.2.1 Anatomy & Physiology		
1.2.2 Respiratory Assessment, Monitoring & Observation		
1.2.3 Non-Invasive and Invasive Ventilation		
1.2.4 Tracheostomy Care		
1.2.5 Chest Drains		
1.2.6 Associated Pharmacology		
1.3 Cardiovascular System		
1.3.1 Anatomy & Physiology		
1.3.2 Assessment, Monitoring & Observation		
1.3.3 Arterial Access		
1.3.4 Central Venous Access		
1.3.5 Managing Fluid Replacement		
1.3.6 Shock		
1.3.7 Cardiac Rhythms		
1.3.8 Associated Pharmacology		
1.4 Renal System		
1.4.1 Anatomy & Physiology		
1.4.2 Assessment, Monitoring & Observation		
1.4.3 Renal Replacement Therapy (RRT)		
1.5 Gastrointestinal System		
1.5.1 Anatomy & Physiology		
1.5.2 Nutrition in Critical Illness		
1.5.3 Assessment and Management		
1.5.4 Associated Pharmacology		
1.6 Neurological System		
1.6.1 Anatomy & Physiology		
1.6.2 Assessment, Monitoring & Observation		
1.6.3 Sedation & Delirium Assessment and Management		
1.6.4 Pain Control		

Continued over page

Step 1: Tracker Sheet continued

Competency Statement	Date Achieved	Mentor/Assessors Signature
1.7 Integumentary System		
1.7.1 Anatomy & Physiology		
1.7.2 Skin Integrity		
1.7.3 Joint Positioning & Range of Movement		
1.7.4 VTE Assessment		
1.8 Medicines Administration		
1.8.1 Regulations		
1.8.2 Administration		
1.9 Admission & Discharge		
1.9.1 Admission to Critical Care		
1.9.2 Discharge from Critical Care		
1.10 End of Life Care		
1.10.1 End of Life Requirements		
1.10.2 Assessment, Decision Making and Initiation of an End of Life Care		
1.11 Intra & Inter Hospital Transfer		
1.11.1 Assisting in the preparation and transfer of the critically ill		
1.12 Rehabilitation		
1.12.1 Rehabilitation Initial Assessment and Referral		
1.13 Communication & Teamwork		
1.13.1 Communicating with Critical Care Patients		
1.13.2 Communication & Team Working		
1.13.3 Communicating in Difficult Situations		
1.14 Infection Prevention & Control		
1.14.1 Infection Prevention & Control		
1.15 Evidenced Based Practice		
1.15.1 Evidenced Based Practice		
1.16 Professionalism		
1.16.1 Maintaining Professionalism		
1.17 Defensible Documentation		
1.17.1 Documentation		
1.18 Mental Capacity		
1.18.1 Mental Capacity & Safe Guarding Adults		
1.19 Leadership		
1.19.1 Demonstrating Personal Qualities		
1.19.2 Working with Others		

1:1 Promoting a positive patient experience

The following competency statements are about the psychosocial needs of a patient during a critical care stay, the competencies outlined need to be applied to all care and treatment undertaken by the registered nurse in the critical care environment

1:1.1 Promoting Psychosocial Wellbeing

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
Concept of holistic care and how it can be incorporated into your practice: • *Physical* • *Psychological* • *Social and family* • *Spiritual and cultural*	
Common feelings experienced by patients 'Waking up' in critical care to include: • Feelings of dehumanisation • Feelings of loss of self • Feelings of loss of control • Feelings of loss of time • Feelings of loss of hope • Feelings of loss of worth • Feelings of loss of reality • Feelings of loss of choice	
Impact of the following on the psychological wellbeing of critical care patients: • Sensory overload • Sleep deprivation • Pain • Confusion • Disorientation • Anxiety • Fear • Night terrors • Hallucinations	
Importance of developing the following with critical care patients: • A trusting relationship • Effective ways of communicating • Individualised family centred care plans	
Assisting patients to: • Regain control as far as possible • Be involved and empower patients to make decisions about their own care and treatment • Promote acceptance of the situation • Move through the grieving process	
• *Importance of giving patients and families clear explanations about care and treatment, always seeking consent before approaching patients to undertake tasks*	

1:1.1 Promoting Psychosocial Wellbeing continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• *Provide emotional reassurance and support*	
• Always act as the patients advocate	
• Demonstrate kindness and compassion in all care undertaken	
• Promote a holistic approach to all care undertaken	
• Orientate patients to time, place and physical location	
• Alleviate fear, stress and anxiety	
• Ensure the patient is comfortable and pain free	
• Promote reality where the opportunity arises	
• Empower patients to regain self-concept and self-control	
• Give adequate explanations regarding care and treatment in a language the patient can understand and repeat these explanations as often as needed	
• Adopt appropriate communication aids; refer to competency Step 1.13.1, 1.13.2 and 1.13.3	
• Encourage and motivate patients to achieve independence in relevant tasks	
• Include patients and family in the development of care plans and treatment choices	
• Be open and honest with patients and families and demonstrate empathy towards their situation	
• Encourage family members to bring in pictures, familiar music and toiletries	
• Encourage patient to accept the situation they find themselves in and promote acceptance where ever possible	
• Respect cultural and spiritual needs	
• Promote normal sleep patterns	
• Reduce sensory overload (particularly during the night)	
• Give explanations for loss of time, consider use of patient diaries	
• Reassure patients that many patients experience similar problems during and following a critical care stay	
• Refer for solution focused therapy or psychological support from relevant multi-disciplinary team members if appropriate	
• Where used keep a clear and accurate account of the patients progress in their diary	
• Encourage patients and their relatives to discuss their experiences of being in critical care, in order for staff to learn from this	
• Provide patients and relatives with written information	
• Signpost patients and relatives to support groups and/or forums (i.e. ICU Steps)	

1:1.2 Visiting in Critical Care

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Importance of visiting and protected rest periods – both to the patient and the relative	
• Local units visiting policy, including children visiting in critical care, refreshments and availability of accommodation	
• Needs of the visitor including what information & facilities are required	
• Awareness of situations of when to discourage visiting or refuse entry to visitors – for example drunk, violent or abusive visitors which would compromise patient, staff & other visitors safety, how to manage these situations, through conflict resolution and who to refer them to	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• Establish a main person who acts as a point of contact for other family members	
• Communicate information clearly taking into account the needs of the relatives/visitor, providing written information if necessary, being aware of what information can be given over the phone	
• Ensure that the environment is conducive for effective communication	
• Document appropriate communication to relatives /visitors in line with local policy (e.g. care plan/case notes/communication folder	
• Assist with any areas for improvement that would enhance the relatives/visitors visiting experience	

1:2 Respiratory System

The following competency statements are about caring for the individual in the critical care environment who requires respiratory support, including monitoring, observation and respiratory care.

1:2.1 Anatomy & Physiology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *The anatomy & physiology involved in respiration:* *o Components of the respiratory system* *o Role & function of the components of the respiratory system in normal respiration* *o Internal & external respiration* *o Gas exchange* *o V/Q mismatch and identify patients at risk*	
• Risk factors for developing respiratory failure: o Type I and Type II respiratory failure and give examples from practice	
• Signs & symptoms of respiratory failure	
• The following conditions: o COPD o Asthma o ARDs o Pneumonia and Ventilator Associated Pneumonia (VAP) o Pulmonary Embolism	

1:2.2 Respiratory Assessment, Monitoring & Observation

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Observation and monitoring of the patient requiring respiratory care including:* *o Normal parameters for respiratory observations* *o Rate/Depth respiration* *o Pulse rate* *o Skin Colour, peripheral and central cyanosis* *o Indications for, and limitations of pulse oximetry* *o Use of accessory muscles* *o Sputum assessment* *o Basic ABG analysis* *- Normal values* *- Respiratory/Metabolic Acidosis/alkalosis* *o Common causes of airway obstruction*	
Actions you would take to restore respiratory function in response to observations including: • *Oxygen therapy* *o Indications for* *o Potential complications* *o Signs & symptoms of oxygen toxicity* *o Various methods of oxygen delivery* *o Humidification* *o Patient positioning* *o Deep breathing exercises* *o Effective coughing*	

1:2.2 Respiratory Assessment, Monitoring & Observation continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• *Provide emotional reassurance and support*	
• *Assess and monitor the patient requiring respiratory support*	
• *Accurately perform and correctly document a full respiratory assessment including:* *o Rate/Depth/pattern of respiration* *o Pulse rate* *o Skin colour* *o Pulse oximetry* *o Use of accessory muscles* *o EtCO2* *o Sputum*	
• *Demonstrate an appropriate response to the observations that you have recorded including:* *o Re-positioning the patient* *o Working with physiotherapist* *o Encourage deep breathing & expectoration*	
• *ABG's* *o Safely perform ABG sampling and report results to appropriate team member* *o Offer basic interpretation* *o Suggest actions following interpretation*	
• *Assemble relevant equipment and administer oxygen therapy via:* *o A simple face mask* *o A venturi system* *o Nasal cannulae* *o Reservoir mask*	
• *Set up and use humidification methods*	
• *Set up and use pulse oximetry* *o Appropriately select probe site* *o Check CRT & proximal pulses*	
• *Provide appropriate intervention for patients experiencing airway problems:* *o Position* *o Head tilt/chin lift/jaw thrust* *o Insertion of airway* *o Manual ventilation*	

1:2.3 Non-Invasive and Invasive Ventilation

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Care and management of the patient requiring Non-Invasive ventilation (NIV) o Indications o Contra-indications o Modes/settings used	
• Process of intubation, including equipment and medications required o Use of capnography o Causes for emergency re-intubation	

1:2.3 Non-Invasive and Invasive Ventilation continued

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Care and management of a patient requiring mechanical ventilation (to include basic modes of mechanical ventilation): o Indications o Contra-indications	
• Modes of ventilation used in the clinical area including: o Spontaneous modes o Pressure controlled ventilation o Volume or time cycled ventilation o Methods of hunidification	
• Normal parameters of ventilation including: *o Rate* *o Tidal volume* *o Minute volume* *o Set pressures* *o PEEP* *o I:E Ratio* *o Pressure support* *o Triggers*	
• Indications for weaning and extubation	
• Management of Secretions including: *o Physiotherapy* *o Indications for suctioning* *o Appropriate monitoring and observations during the procedure* *• Potential complications associated with suctioning* *o Correct pressure* *o Correct sized suction catheter* *o Correct procedure*	
Sub-glottic suctioning	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
Under supervision and with appropriate support, manage the patient who requires:	
• Non-invasive ventilation: *o Accurately monitor & document ventilator observations* *o Seek support & advice as appropriate* *o Set alarm limits appropriately for specific patients*	
• Intubation: o Complete ABCDE assessment of the patient about to undergo a rapid sequence induction o Identify and discuss role of airway adjuncts, intubation equipment, difficult airway equipment and specific medications o Prepare patient o Prepare medications o Assist during procedure o Secure ETT/tracheostomy tube o Check and confirm position of tube o Document length and position of tube o Check cuff pressure	

1:2.3 Non-Invasive and Invasive Ventilation continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Invasive ventilation: o Accurately monitor & document ventilator observations o Seek support & advice as appropriate o Set alarm limits appropriately for specific patients o Adhere to the Ventilator Care bundle o Monitor Et CO2 o Appropriately care for a patient during weaning o Recognise when extubation is appropriate o With support, extubate the patient o Care for the patient post extubation	
• Suctioning: o Select appropriate suction pressures o Select appropriate catheter size o Suction using the correct technique via: - Naso-oro pharyngeal - ET tube - Tracheostomy o Monitor the patient prior to, during and after suctioning o Accurately monitor & chart findings o Inform/liaise with relevant MDT members o Practice in a manner that will minimise cross infection o Correctly and safely dispose of container/contents/suction equipment as per local policy	

1:2.4 Tracheostomy Care

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Anatomical position of tracheostomy*	
• *Indications for insertion of a tracheostomy*	
• *Types of tracheostomies* *o Percutaneous tracheostomy* *o Surgical tracheostomy* *o Mini tracheostomy*	
• *Knowledge of tracheostomy care bundle and NCEPOD best practice standards*	
• *Importance of:* *o Securing tube safely* *o Changing/cleaning inner-tube* *o Checking cuff pressures* *o Wound care management*	
• *Tracheostomy emergency algorithm and best practice standards, including bedside safety equipment, escalation for blocked tube, unplanned decannulation (Refer to national and local guidelines)*	
You must be able to undertake the following in a safe and professional manner	
• *Provide emotional reassurance and support*	
• Care for the stoma site	
• Clean and change the inner tube	
• Observe an insertion of a percutaneous tracheostomy	
• Appropriately monitor the patient following tracheostomy insertion	
• Observe a decannulation	
• Appropriately monitor the patient following decannulation	
• Appropriately plan & deliver care in line with national/local guidelines	
• Outline associated swallowing assessments processes and difficulties	

1:2.5 Chest Drains

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Indications for chest drain insertion including: o Pneumothorax o Haemo-pneumothorax o Pleural effusion o Empyema	
• General care and management: o Indications for use of chest drain clamps o Drainage o Swinging o Bubbling o Bottle changes o Dressings o Removal	
• Application of low thoracic suction to a chest drain	
• Potential complications associated with chest drains	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Manage the patient with a chest drain in situ	
• Prepare the equipment ready for insertion	
• Observe and assist with chest drain insertion	
• Perform routine respiratory observations	
• With support undertake correct action if: o Drain blocks/falls out o There is an air leak from around the stoma site o Bubbling stops o Underwater seal is lost o Tension pneumothorax develops	
• Effectively manage the drain: o Position of bottle o Appropriate/cautionary use of drain clamps, in line with local guidance o Dressings o Changing/disposal of bottles o Monitoring drainage o Application of low suction	

1:2.6 Associated Pharmacology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Commonly used medications for respiratory care, o Bronchodilators/Nebulisers o Steroids o Sedation/paralysing agents o Antibiotics o Analgesia	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Safely prepare and administer medications as above to support the respiratory system	
• Monitor effects of medication	

1:3 Cardiovascular System

The following competency statements are about monitoring and caring for the individual in the critical care environment who is suffering from cardiovascular dysfunction.

1:3.1 Anatomy & Physiology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Structure and function of the heart (include chambers and valves)	
• Identify major/minor blood vessels	
• Oxygenated/deoxygenated blood flow	
• Determinants of the normal cardiac cycle	
• Determinants of blood pressure (BP= COxSVR)	
• Determinants of central venous pressure	
• Cardiac Conditions: o Hypertension o Peripheral Vascular Disease o Angina (stable/unstable) o Myocardial Infarction o Left Ventricular Failure o Cardiomyopathy o Acute Coronary Syndrome	

1:3.2 Assessment, Monitoring & Observation

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Indications for haemodynamic monitoring in relation to the critically ill adult: o Invasive o Non-Invasive	
• Sepsis identification criteria: o SIRS criteria o Sepsis criteria (2 SIRS criteria + actual or presumed infection) o Severe Sepsis criteria (Sepsis + evidence of organ dysfunction) o Red Flag Sepsis criteria (non-laboratory Severe sepsis criteria + HR, RR or AVPU)	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Assess and monitor the patient requiring cardiovascular support	
• Accurately perform and correctly document a full cardiovascular assessment including: *o Pulse/ECG* *o Blood pressure including MAP* *o Temperature* *o Urine output* *o Fluid therapies* *o Capillary refill time* *o Skin turgor* *o Limb temperature* *o Blood results* o Biochemical markers	

1:3.3 Arterial Access

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Choice of arterial cannula sites*	
• *Associated hazards and complications of arterial cannulas/lines*	
• *Normal and abnormal arterial waveform patterns*	
• *Reasons for the removal of an arterial cannula*	
• How a transducer system works	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• *Prepare for and assist in the safe insertion of an arterial cannula*	
• *Correctly prepare and prime a transducer system*	
• *Correctly attach a transducer to an arterial cannula*	
• *Correctly zero a transducer system*	
• *Correctly identify when re-zeroing is required*	
• *Correctly set appropriate alarm limits*	
• *Apply an appropriate dressing in accordance with local policy*	
• *Correctly obtain a blood sample from the arterial cannula*	
• *Safely remove an arterial cannula*	

1:3.3 Central Venous Access

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Choice of sites for central venous access	
• How a transducer system works	
• Associated hazards and complications of central venous catheters and systems	
• Normal and abnormal waveform patterns	
• Reasons for the removal of a central catheter	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• *Safely prepare for and assist with the insertion of a central venous catheter*	
• Position the patient for insertion/removal of a central venous catheter to minimise hazards but maintain safety at all time	
• *Discuss checking the line position before use in accordance with local policy*	
• *Correctly prime a transducer system*	
• *Correctly attach a transducer to a central venous catheter*	
• *Correctly zero a transducer system*	
• *Correctly identify when re-zeroing is required*	
• *Correctly set appropriate alarm limits*	
• *Apply an appropriate dressing in accordance with local policy*	
• Correctly obtain a venous sample from the central line	
• Safely remove a central line	

1:3.5 Managing Fluid Replacement	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Clinical indications that necessitate fluid intervention	
• Differences between colloids, crystalloids and blood products	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• Recognise altered fluid status	
• Recognise the requirements for fluid intervention	
• *Correctly administer fluids according to local guidelines*	
• *Accurately record fluid balance according to local policy*	

1.3.6 Shock	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Classifications and treatment of : o Cardiogenic Shock o Hypovolemic Shock o Distributive Shock including: - Septic Shock - Neurogenic Shock - Anaphylactic Shock	
• Recognise and interpret signs and symptoms of all the above	
You must be able to undertake the following in a safe and professional manner:	
• *Provide patient with explanation, reassurance and support*	
• Correctly follow local and national treatment protocols for the management of shock	
• Assess the effectiveness of the prescribed treatments and interventions and escalate any concerns appropriately	

1:3.7 Cardiac Rhythms	
You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Normal cardiac conduction pathway*	
• Monitoring and interpretation of basic 3 or 5 lead ECG	
• Normal sinus rhythm	
• *Life threatening cardiac dysrhythmias* *o Atrial Fibrillation* *o Ventricular Tachycardia* *o Ventricular Fibrillation* *o Asystole* *o Pulseless Electrical Activity (PEA*	
• Other common cardiac dysrhythmias	
• Your role within then cardiac arrest team	
• Key resuscitation equipment *o Location of equipment* o Application and use of resuscitation equipment	
• Emergency drugs used in to cardiac arrest	
• Post arrest management strategies	

1:3.7 Cardiac Rhythms continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Provide emotional reassurance and support	
• Correctly attach the patient to a cardiac monitor	
• Correctly check 'emergency' equipment including defibrillator	
• Correctly identify: *o Bradycardia* *o Tachycardia* o Ectopic beats o Atrial fibrillation o Atrial flutter	
• Correctly identify and follow BLS/ILS guidelines where appropriate for the following life threatening dysrhythmias: *o Asystole* o Pulseless Electrical Activity (PEA) o Ventricular tachycardia *o Ventricular fibrillation*	

1:3.8 Associated Pharmacology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Indications for and the basic effects of the following medications (giving examples of those commonly used within your own area): o Inotropes o Vasopressors o Vasodilators o Anti-arrhythmics o Anti-hypertensive o Diuretics	
• Indications for choice and the following fluid challenges: o Crystalloids o Colloids o Blood products	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Safely prepare and administer medications used to support the cardiovascular system	
• Titrate medication under supervision to achieve targets set by medical staff (e.g. MAP, systolic pressure)	

1:4 Renal system

The following competency statements are about the safe and effective assessment of renal function, monitoring of fluid balance and care of the patient at risk of acute kidney injury in the critical care environment, including Renal Replacement Therapy.

1:4.1 Anatomy & Physiology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Renal System*	
• *Functions of the kidney*	
• Production of urine	
• Elimination of electrolytes	
• Renal blood supply	
• Causes of acute kidney injury o Pre-renal - Volume depletion - Dehydration - Sepsis - Heart Failure o Intra-Renal (intrinsic kidney failure) - Glomerular disease - Toxins (inc. nephrotoxic drugs) - Contrast Medium - Untreated pre-renal failure o Post–renal (obstruction) - Blocked urinary catheter - Stones - Enlarged prostate	

1:4.2 Assessment, Monitoring & Observation

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Methods of measuring and recording fluid output:* *o Urine output* *o Fluid loss from drains* *o GI loss (including vomit, naso-gastric drainage, faeces)* *o Problems recording loss during operative procedures* *o Bleeding (external and internal)* *o Insensible loss (different routes and specific patients at risk)*	
• Methods and techniques for monitoring the fluid status, balance and renal function of individuals in critical care at risk of renal deterioration: o Cardiovascular monitoring, refer to competency Step 1:3.2 o Recognition of fluid depletion o Recognition of fluid overload o Maintenance of daily fluid balance charts o Patient weight o Urine output relative to weight o Renal blood profile o Creatinine clearance	
• Basic considerations in renal failure: o Nephrotoxic drugs o Drug dose adjustments in renal failure o Fluid overload o Hyperkalaemia	

1:4.2 Assessment, Monitoring & Observation continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Provide emotional reassurance and support	
• Determine the monitoring needs for the individual at risk of deteriorating renal function	
• Demonstrate the ability to accurately measure and record fluid balance and reports abnormalities appropriately	
• Monitor and review a patient's biochemistry and haematology results as directed	
• Identify normal parameters of Urea & Creatinine, Potassium, Chloride, Sodium, Bicarbonate, Haemoglobin	
• Identify factors which may affect the assessment of renal function (e.g. blocked catheters and urinary retention)	
• Evaluate the effectiveness of fluid replacement	
• Administer appropriate care to the patient with a urinary/urinary tract catheter (according to national guidelines and local policy)	
• Utilise locally available equipment o Catheterisation equipment o Urometers	
• Weigh patients routinely in line with local policy	
• Record hemodynamic parameters as directed	
• Appropriately seek help in the presence of abnormal physiological/pathological results	

1:4.3 Renal Replacement Therapy (RRT)

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• The indications for RRT o Fluid overload o Hyperkalaemia o Metabolic acidosis o Toxin clearance	
• The terms ultrafiltration, convection and diffusion	
• The types of RRT available o CVVH o CVVHD o CVVHDF o SLEDD	
• The complications associated with RRT and how these can be managed/prevented o Haemodynamic instability o Air Emboli o Platelet consumption o Blood Loss o Electrolyte imbalances o Hypothermia o Heparin induced bleeding or thrombocytopenia	
You must be able to undertake the following in a safe and professional manner:	
NB. The competencies below are to be achieved in centres which deliver RRT	
• Provide emotional reassurance and support	
• Assist with vascular catheter line insertion, maintaining asepsis	
• Prepare the equipment required	
• Set up the filter ready for use	
• Explain the importance of correctly setting the fluid access/ loss setting	
• Explain the use of anticoagulation, the types used, how to make them up and the starting doses of each	
• Connect the patient to the treatment therapy utilising an aseptic technique	
• Change prescribed filtration fluids, and empty effluent bags adhering to infection prevention principles	
• Record appropriate filter pressures and explain their relevance, including signs of filter clotting	
• Identify the main alarm categories and their relevance	
• Perform point of care testing (as appropriate) and adjust anticoagulant accordingly	
• Identify what selections are available to end treatment and demonstrates how to end treatment, appropriately disposing of waste products according to local infection prevention guidelines	
• Clean filtration machine in line with local policy and store as appropriate	

1:5 Gastrointestinal System

The following competency statements are about the safe and effective care of the critically ill patient requiring nutritional support and management of gastrointestinal (including the Liver & Biliary system) dysfunction.

1:5.1 Anatomy & Physiology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Gastrointestinal tract and metabolism: o Oral cavity and swallowing o Oesophagus o Stomach o Small bowel o Large bowel o Appendix o Rectum	
• Pancreas: o Function and production of insulin o Role of pancreatic enzymes	
• Liver & biliary system: o Liver o Gall Bladder o Common bile ducts o Spleen	
• Causes of gastrointestinal dysfunction: o Obstruction o Inflammation o Perforation o Infection o Ulceration o Factors that may affect motility (sympathetic and parasympathetic, drugs, surgery)	
• Causes of pancreatic dysfunction: o Pancreatitis o Obstruction o Diabetes (Type 1 and 2) o Cystic Fibrosis	
• Causes of Liver or biliary dysfunction: o Obstruction o Inflammation o Infection o Perforation o Cirrhosis	

1:5.2 Nutrition in Critical Illness

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Factors contributing to nutritional impairment in critical illness	
• Nutritional assessment tools appropriate for use in critical care	
• Local nutritional care bundles in critical illness	
• Different types of feeding and the indications for use: o Nasogastric/NJ /gastrostomy (PEG /RIG) o Parental nutrition o Oral	
• *Stomach/intestinal fluid aspiration:* *o Normal appearance and content of stomach/intestinal fluid* o Potential abnormal appearance and content of stomach/intestinal fluid depending on the individuals presenting medical condition	
• *Nasogastric insertion in critical care*	
• *Correct placement of nasogastric tubes (local policy & NPSA guidance)*	
• *Confirming placement by pH testing and CXR (when indicated)*	
• Prevention and treatment of blocked enteral feeding tubes	
• Care of enteral feeding tubes	
• Types and benefits of various feeding tubes	
• Care of parenteral nutrition lines	
• Complications of nasogastric feeding in critical illness	
• Complications of parentral nutrition	
• Re-feeding syndrome related to local policy and guidelines	
• Referral to dietician team	
• Referral to pharmacy team	
• Management of bowel function in critical care	
• Nutritional needs of adults and how to maintain a healthy gut: o Food groups required o Calorific intake o Normal blood sugar levels	
• Types of nasogastric feed	

1:5.2 Nutrition in Critical Illness continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• *Provide emotional reassurance and support in relation to assessing the patients nutritional requirements*	
• *Perform an assessment of the patient's nutritional status using an appropriate tool or local protocol*	
• *Manage the care of a patient with a nasogastric tube including:* *o Method of Insertion (depending on tube type)* *o Correct positioning of patient* *o pH testing and understand normal values* *o Correct external measurement* *o When to x-ray* *o Absorption and aspiration*	
• *Administration of medication:* *o Correct anchoring of NG device* *o Monitoring for pressure sore prevention* *o Correct size and appropriate tube selection*	
• Manage the care of a patient with a naso-jejunal tube; insertion, position and care of tube	
• Safely prepare and administer parental nutrition in line with local policy	
• On-going assessment of nutritional needs and intervene as appropriate	
• Liaise with the MDT where appropriate	
• *Monitor patients during nutritional support*	
• Obtain regular blood profiles	
• *Monitor and control blood glucose in critically ill patients according to local policy*	
• Identify the patient with constipation or diarrhoea utilising appropriate assessment and recording tools	
• Instigate and take appropriate measures to manage constipation and diarrhea, including: o Fluid management o Pharmacological management o Tissue viability issues o Patient dignity o Utilises local bowel management protocols appropriately (faecal collection systems) o Adheres to local guidelines for managing constipation o Adheres to local guidelines for management of C-Diff	
• Identify at risk/high/severe risk re feeding patients in line with policy and criteria	
• Replace electrolytes and follow reduced calorific nutrition as per local policy for any patient suffering from re-feeding syndrome	

1:5.3 Assessment and Management

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Assessment of bowel sounds*	
• Surgical procedures: o Hartmann's procedure o Oesophogectomy o Colectomy	

1:5.3 Assessment and Management continued

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Acute GI conditions: o Pancreatitis o GI bleed o Oesophageal varices o Duodenal ulcers	
• Chronic Liver impairment: o Alcoholic liver disease	
• Acute liver & biliary impairment: o Overdose of toxins o Biliary sepsis	
• Differing types of stomas and adjuncts: o Ileostomy o Colostomy o Ileal Conduit	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support in relation to assessing the patients nutritional requirements*	
• Determine the monitoring needs for the individual with altered gastro-intestinal function relevant to the underlying pathophysiology	
• *Accurately measure and record nutritional status and report abnormalities appropriately*	
• *Follow guidelines in the management of blood glucose control and feeding regimes*	
• Monitor and review a patient's biochemistry and haematology results	
• Evaluate the effectiveness and tolerance of nutritional intake	
• Administer appropriate care to the patient with enteral and parental devices (according to national guidelines and local policy)	
• Weigh patients routinely in line with local policy	
• Care for the tunnelled feeding line according to policy	
• Manage stoma and/or drains in accordance with national and local policy and guidelines	
• Monitor and document stoma site appearance (such as colour, positioning, functioning) and escalate any concerns	

1:5.4 Associated Pharmacology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Commonly used medications for GI management: o Prokinetics & motility o Laxatives o Anti-stimulants o Insulin/ hypoglycaemic agents o Probiotics • Discuss when the above are unsuitable and/or contraindicated	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support in relation to GI drug administration*	
• Safely prepare and administer medications used to support the gastrointestinal system	
• Titrate medication to achieve targets set (e.g. blood glucose control)	

1:6 Neurological System

The following competency statement is about the assessment and management of the neurologically compromised patient in the general critical care environment.

1:6.1 Anatomy & Physiology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Gross structures of the nervous system*	
• Pupil responses o How they are regulated o Abnormal responses and possible causes including focal and generalised deficit	

1:6.2 Assessment, Monitoring & Observation

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Purpose of neurological assessment tools:* *o AVPU tool* *o GCS tool*	
• Recommended frequency of GCS assessment and escalation of frequency	
• *Logical steps to assess each component*	
• Scoring system for eye opening: o Correct method of assessment of eye opening to voice and painful stimulus o Correct type of painful stimulus to assess for eye opening o Correct method for assessing pupil response to light including direct and consensual light reflexes as an adjunct to GCS	
• Scoring system for verbal/sound response: o Correct method of assessing orientation and verbal/sound response o Focal verbal deficit such as aphasia, receptive and expressive dysphasia	
• Scoring system for motor response: o Recording of best limb response from arms o How to identify the ability to obey commands o Comparing left to right to identify focal deficit o Differentiating between normal power, mild weakness and severe weakness o Use of correct method of painful stimulus when assessing limb response o Reflex arc o Correct use of trapezius pinch o Contra-indications to orbital pressure and sternal rub o Correctly identify ability to localise o Correctly identify flexion o Correctly identify abnormal flexion o Correctly identify extension o Correctly identify no response	
• Limitations of the GCS as an assessment tool: o Assessment of vital signs to ensure there is a complete data set: o AVPU score for assessing conscious level compared to GCS assessment o Adjuncts to the GCS for detecting deterioration in clinical condition such as NEWS or local track and trigger tool	
• Intracranial and extracranial reasons for deteriorating GCS	

1:6.2 Assessment, Monitoring & Observation continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• *Provide emotional reassurance and support*	
• Accurately assess AVPU or GCS and record it	
• Identify deterioration in level and seek appropriate advice and guidance	
• Identify focal deficits such as; gag and swallow reflexes, pupil, verbal and limb responses and correlate with anatomy and physiology	
• *Identify the need for airway protection in a patient with a deteriorating GCS*	

1:6.3 Sedation & Delirium Assessment and Management

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Relevant best practice, care bundle and NICE guidance: o Strategies to prevent, recognise and treat delirium o Screening for risk factors on admission o Person centred care o Mental Capacity Act o Importance of accurate assessment/recording and communication between care teams, patient and family	
• Characteristics of delirium: o Changes in mental state o Inattention o Disorganised thinking o Altered consciousness	
• Three clinical subtypes of delirium and their presentation: o Hyperactive o Hypoactive o Mixed	
• *Assessment of delirium using appropriate tool e.g. CAMICU*	
• Treatment options if delirium is diagnosed	
• Sedation and indications for use	
• *Assessing the adequacy of sedation using a sedation scoring tool*	
• Different sedation scoring systems available	
• Strategies for administering sedation	
• Types of sedation used in the context of critical care and their effects	
• Importance of sedation holds	

1:6.3 Sedation & Delirium Assessment and Management continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• *Provide emotional reassurance and support*	
• Confirm the desired sedation level for the patient	
• Safely administer sedation in accordance with local sedation guidance and prescription	
• Correctly assess patients' sedation level using the local sedation scoring system	
• *Accurately record sedation levels at the recommended time intervals in line with local guidance*	
• Perform sedation hold as directed	
• Assess the need for re-sedation	
• *Care for the sedated patient in relation to:* *o Airway protection* *o Mechanical ventilation* *o Hygiene needs* *o Pressure area care* *o Nutritional needs* *o Privacy and dignity*	
• Safely administer and monitor the effect of prescribed pharmacological therapy, in accordance with local policy	
• *Inform medical and senior nursing staff of problems if desired sedation levels cannot be achieved*	
• Undertake delirium risk assessment	

1:6.4 Pain Control

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Anatomy and physiology relating to pain perception	
• Concept of pain as the 5th vital sign	
• Basic pain categories: o Chronic pain o Acute pain o Break through pain o Withdrawal pain o Neuropathic pain	
• *Methods of pain assessment and non-verbal signs of pain:* *o Utilisation of a pain measurement tool and when to seek medical intervention* o Site, onset, character, radiation, timing, exacerbating and relieving factors o Types of pain and their likely origin: - Rebound tenderness in the abdomen - Musculoskeletal pain - Incisional pain - Neuropathic pain	
• Importance of excluding causes of agitation such as: o Constipation o Full bladder and/or blocked urinary catheter o Hypoxia o Poor positioning o Incontinence	

1:6.4 Pain Control continued

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Pharmacological treatment options for different types of pain: o Opioid medications o Non-opioid medications o Adjunct medications such as amitriptyline o Non-steroidal anti-inflammatory drugs o Patient controlled analgesia (PCA) and Epidurals o Anticonvulsants such as gabapentin and carbamazepine o Analgesic skin patches	
• Analgesic drugs commonly used in ICU, their effects and side effects	
• Advantage of using analgesic drugs in combination with each other	
• Non pharmacological strategies for pain control: o Deep breathing exercises o Use of heat and cold o Reassurance and control of environmental stimulus o Positioning for comfort	
• Use of relaxation and diversion, limiting the noise and lighting	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Assess pain score using local scoring system and document findings clearly	
• Assess and document of physiological signs of pain	
• Adjust analgesic infusions as prescribed and administer other prescribed analgesics according to local policy	
• Use positioning and posture to maximise patient comfort	
• Discuss problems with the MDT ensuring pain relief is reviewed in a timely manner	
• Ensure good communication between the patient and MDT	
• Demonstrate safe use and recording of PCA and epidural devices	
• Discuss with the patient the need for and safe use of the PCA/Epidural device	

1:7 Integumentary System

The following competency statements are about maintaining skin integrity and positioning patients in the critical care environment.

1:7.1 Anatomy & Physiology

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Skin: o Layers of the skin o Accessory organs o Functions of the skin	
• Muscular Skeletal: o Major skeletal muscles and their structure o Associated connective tissues o Loss of muscle tone o Identification of joints	

1:7.2 Skin Integrity

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Risk assessments and the nursing responsibilities related to patients at risk of pressure damage	
• High risk areas of the body for pressure damage	
• Grades 1- 4 pressure damage (using the European Pressure Ulcer Advisory Panel – EPUAP)	
• Differences between: o Pressure damage o Moisture lesions o Shear and/or friction force damage	
• Practice required to prevent pressure damage: o Surface o Keep moving o Incontinence / moisture management o Nutrition	
• Various pressure relieving devices available locally and the agreed pathway for accessing these	
• Local reporting system for pressure related damage	
• Importance of collecting and auditing data on pressure area damage in order to improve pressure area care within the clinical area	
• Associated costs of pressure damage: o Cost to the patient in terms of delayed rehabilitation and pain o Financial costs	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Surface management: *o Risk assess the patient's skin using an appropriate risk assessment tool* *o Determine the appropriate surface for the identified risk and to locate the correct surface* *o Assess correct use of devices/equipment and that they are in good working order (in accordance to local policy)* *o Ensure regular visual checks of at risk areas are carried out*	

1:7.2 Skin Integrity continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Keep moving: *o Encourage the patient to change their position or be repositioned* o Manage people and equipment resources in order to achieve positioning objectives, such as the maximum length of time a patient is sitting out in a chair *o Regularly reposition unconscious patient in line with local policy or skin bundle* *o Minimise shear and/or friction damage with correct use of manual handling devices* o Increased moisture damage and incontinence management: *- Identify moist or wet skin* - Treat dry skin with moisturisers *- Cleanse the skin at the time of soiling and use topical agents that act as moisture barriers* - Identify incontinence associated dermatitis, and differentiate this from pressure damage - Offer toileting opportunities based on identified individual need - Instigate any incontinence device in line with local policy	
• Nutrition: o Refer to competency Step 1.5.2 *o Report any pressure damage in line with local policy* o Measure the reliability of the care delivered within the clinical area by measuring both pressure damage outcomes and compliance with processes o Prevent pressure damage from endotracheal tube holders, by either repositioning as needed, or using commercial products that avoid pressure o Refer patients to other members of the MDT when specialist input is needed: - Tissue viability - Dietician - Speech and language therapy - Occupational therapy - Physiotherapy	

1:7.3 Joint Positioning & Range of Movement

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Concept of 'range of movement' and the anatomical structures that could be damaged by poor joint positioning	
• Joints that are most at risk of damage	
• Concept of foot drop	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Undertake a full range of passive exercises for the patient at the time intervals specified	
• Position patients ankles to reduce the risk of foot drop	
• Apply any appropriate ankle/foot splint for patients at high risk of foot drop	
• Identify patients at high risk of joint damage (e.g. long stay, oedematous)	
• Position shoulders to prevent excessive joint stretch when lying a patient on their side	

1:7.4 VTE Assessment

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Importance and need to assess all patients admitted to hospital against the VTE assessment	
• Importance of assessing the patients level of mobility	
• Need for all patients (both surgical and medical patients) with significantly reduced mobility to be further VTE risk assessed	
• Need to review the patient-related factors identified on the risk assessment against thrombosis risk	
• Why any patient at risk of thrombosis should receive thromboprophylaxis in accordance with NICE guidance and local policy	
• Types of thromboprophylaxis: o Pharmacological o Mechanical	
• Complications of pharmacological VTE prophylaxis	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Identifies and documents risks identified to the individual patient	
• Instigates mechanical prophylaxis in line with local policy	
• Safely administers prescribed pharmacological prophylaxis	
• Involves patient in prevention of thrombosis as appropriate	
• Reviews VTE risk assessment in line with local policy	

1:8 Medicines Administration

The following competency statements are about the safe administration of pharmaceutical interventions in critical care, including the management of an individual's medication regime in order to achieve optimum outcomes, they applies to all routes of administration.

1:8.1 Regulations

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *National and local legislation, guidelines, protocols and policies for the administration of medication:* *o Medicines Act* *o Mixing Medicines* *o Misuse of Drugs Act* *o NMC Code of Professional Conduct* *o NMC Medicines Administration Standards* *o CC3N Clarification Statement*	
• *Health & Safety regulations relevant to medicines administration in critical care:* *o COSHH* *o Safe handling and disposal of sharps* *o Standard precautions & personal and protective clothing/equipment* *o Hand hygiene*	
• *Legal and ethical consideration of medication:* *o Legal requirements* *o Capacity Assessment* *o Informed consent* *o Acting in the patients best interest*	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• Take responsibility as an administrator under the listed guidance	

1:8.2 Administration

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Process of administration in critical care and the importance of working within your own scope of practice: o Consent o Prescription checks o Preparation of medications/infusions o 2nd registered nurse checks o Administration of medications o Monitoring during administration o Titration of medications to optimise outcomes o Safe discontinuation of medications/infusion o Monitoring post administration o Safe disposal of equipment/administration devices o Supervision & training of others o Role and responsibility of prescribers	

1:8.2 Administration continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Provide emotional reassurance and support	
• Identify the correct patient always seeking positive confirmation of the individual's identity before starting the preparation of medicines in critical care, in both: o Conscious patients o Unconscious patients	
• Obtain and review a critical care patient's medication history: o Allergies and sensitivities o Pre admission medication review o Regular medications and their effects on critical illness and presenting condition o Critical care medications and their effects on pre-existing co-morbidities	
• Adherence to the following practices used in critical care to minimise the risk of harm to the individual or reduce the risk of error in medication and fluid administration: o Identity check o Prescription check o Weight check o Prescriber and administrators responsibilities o 2nd Registered nurse check o Required and/or continuous monitoring and observation during administration o Knowledge of the medication and the expected effects on the individual	
• Use the 5 R's when administering any medication: o Right patient o Right medication o Right dose o Right route o Right time	
• Prepare and use administer medications in critical care adhering to the following guidance: o NMC Code o NMC Medicines Administration Standards o CC3N Preparation in Advance Statement	
• Apply local policy for infusion device competencies for: o Volumetric infusion pumps o Syringe pump/driver	
• Consider the route of administration: *o Oral* *o Sublingual* *o Nasogastric* *o Nasojejunal* *o Orogastric* *o Rectal* *o Topical* *o Intra muscular injection* *o Subcutaneous injection* o Intravenous bolus o Continuous intravenous infusion o Epidural infusion o PCA o Subcutaneous syringe driver	

1:8.2 Administration continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Where appropriate indicate to the prescriber the route most appropriate to the patient	
• Access information in relation to drug administration if you are unfamiliar with the prescribed medication: o Critical care pharmacist o On call pharmacist o Injectable medicines guide (MEDUSA) o Enteral medication guidelines o BNF o On line data sheet compendium o Manufactures instructions o Local administration guidance	
• When preparation of medications: o Demonstrate competence in mathematical calculations in line with local policy o Calculate the correct amount of medication prescribed and the correct diluent o Select compatible infusion fluid o Calculate the correct infusion rate o Label medication/infusion in accordance with your local policy	
• Select the appropriate type of equipment to use in relation to the medication being administered and the route of administration prescribed: o Consumables, taking into account local policy for line changes o Infusion devices o Tamper evident syringes or bags, where appropriate o Oral syringes for enteral preparations o Gloves/lubricant for rectal	
• Identify and manage signs of anaphylaxis: o Early identification o Signs and symptoms o Emergency treatment o Communication with multidisciplinary team o Continuous monitoring and re evaluation o On-going treatment of anaphylaxis o Reporting of anaphylaxis, in line with local policy	
• Review of regular prescriptions	

1:8.3 Intravenous Administration: Optimising Patient Outcomes

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Need for continuous monitoring and observation of the patient during administration	
• Importance of evaluating an individual's progress during infusion/treatment and manage their medication to achieve optimum outcomes	
• IV devices & routes: o Peripheral access sites and devices o Central access sites and catheters o Long lines	
• Complications associated with IV administration via: o Peripheral access o Central access o Long lines	
• Infection risks associated with IV administration	
• Principles of asepsis in relation to the use of pharmaceuticals and equipment: o Hand hygiene o Infection control measures o ANTT practice o CVP Vs peripheral access o Line related sepsis	
• Potential consequences of poor practice and how this can affect the critically ill patient and inhibit their recovery	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Use medication regimes in practice to titrate medications within prescribed limits	
• Increasing or decreasing the infusion rates as appropriate	
• 'Piggy back' or wean off medications as appropriate	
• Safely mix medications in the Y connecter	
• Identify the physiological effects to the patient expected during administration and monitor the patient appropriately	
• Appropriately take into account effects on and effects of fluid and electrolyte balance in relation to drug administration	
• Identify how medication are commonly eliminated from the body	
• Choose appropriate type of access for administration depending on: o Concentration o Potency o Rate of delivery o Irritancy	
• Check line sites and act appropriately if there is evidence of: o Irritation o Inflammation o Swelling o Infection o Loss of sensation	
• Reduce the risk of line related infections by considering the following: o Frequency of dressing changes o Type of dressing used o Silver coated devices o Antibiotic impregnated devices	

1:9 Admission & Discharge

The following competency statements are about immediate patient care on admission to the critical care environment and safe discharge back to a level 1 area.

1:9.1 Admission to Critical Care

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Indications and rationale for patient admission to the critical care setting	
• The nursing responsibilities related to patient admission processes	
• Value of effective teamwork and communication processes: *o Personnel referring, transferring and receiving the patient* *o Identifying the patients' condition and care needs*	
• Significance of initial patient physical and psychological assessments	
• Referral process and associated challenges of: *o Emergency admissions* *o Elective admissions* *o Repatriations*	
• Range of relevant trust, unit, network policy documents that support patient admission to critical care o Essential Trust Documentation o Operational Guidance for Critical Care Services o Critical Care Admission, Referral and Repatriation Policies o Outreach teams and/or other supportive structures	
• Importance of the nurses role associated with the support and providing information for accompanying family members/carers or patient representatives on admission	
• Importance of discussing the patients usual special needs or requirements with the family: (including but not exclusive to): *o Hearing aids* *o Glasses* *o Mobility aids/equipment*	
• Importance of providing the family with timely updates and explanations	
• Importance of providing families with the time and opportunity to ask questions and discuss any concerns	
• Importance of obtaining infection control status and performing relevant infection control screens, refer to competency Step 1.14.1	
• The issues related to data protection and patient confidentiality	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Collate, prepare and complete appropriate documentation in electronic and paper formats for admission (inclusive of but not limited to): *o Completion of ICNARC and patient data bases* *o Completion of care plans* *o Completion and use of handover documentation*	
• Preparation of supportive equipment (inclusive of but not limited to): *o Bed/mattress* *o Monitors* *o Oxygen, suction, re-breathing circuit, ventilator* *o Volumetric pumps* *o Disposables and PPE* *o Safety equipment*	

1:9.1 Admission to Critical Care continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Demonstrate proficiency in receiving the patient, assessing, recognising and implementing the priorities associated with care activities (inclusive of but not limited to): o Physical and psychological assessment processes: o A,B,C,D,E assessment o Mental Capacity	
• Ascertain the patients infection risk and take appropriate step to isolate and instigate protective equipment as required	
• Safely handle the patient, equipment and the patient's property	
• Provide timely information to family/carers or patient representatives as appropriate and document the information you relayed	

1:9.2 Discharge from Critical Care

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Current national, network and local policies, protocols and guidelines in relation to the discharge of patients from a critical care area: o NICE CG 50 o NICE CG 83 o Outreach follow up	
• Importance of a full medication review prior to discharge and the need for all medications and fluids to be prescribed before stepping the patient down: *o Types and methods of taking different medications* o Effects, side-effects and potential interactions of different medications and how these should be accounted for in the discharge plan	
• Roles and responsibilities of all MDT members involved in critical care patients discharge planning	
• Different requirements that need to be considered to support the patients personal and socio-cultural needs following a critical care stay	
• Importance of keeping the individual and family members informed, offering reassurance about what you are doing and any relevant aspects involved in the development of the discharge plan: o Removal of lines o Removal of monitoring o Follow up/rehabilitation process	
• Importance of considering the individual's communication difficulties/ differences & level of knowledge and understanding about the discharge process	
• Importance of establishing that the patient has understanding, can recall and repeat information provided	
• The range of services provided locally that may be required on discharge from critical care: o Outreach o Pain Service o Dietician o Physiotherapy o Occupational therapy o Palliative and end of life care services	
• MDT members responsible for each aspect of the individuals' care plan and rehabilitation needs, and how to appropriately contact them and inform them of the patients discharge from critical care	
• Types of information that must be recorded in relation to different aspects of the discharge plan: o Discharge summary of critical care stay o Condition at time of discharge (system based approach) o Continuing treatment and rehabilitation plans *o Infection risk* *o Invasive lines/devices* *o Equipment required*	

1:9.2 Discharge from Critical Care continued

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *The additional considerations you need to make when discharging a patient with a tracheostomy:* *o Tracheostomy passports/pathways* *o Safety equipment* *o Emergency algorithms* *o Designated wards* *o Ward staff capacity and capability to receive patients safely* o Tracheostomy education & training o Decannulation *o Time of discharge* o AHP support	
• Organisational issues that can impact on patient flow through critical care and the challenges this may cause	
• Importance of Critical Care Outpatient follow up services	
• Importance of Critical Care support groups for patients and family/carer	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• Review all progress reports and interpret the results of observations, tests, assessments and interventions prior to discharge	
• Remove all invasive lines/device that are no longer required	
• *Discontinue all appropriate monitoring*	
• Obtain a full blood profile in line with local policy and NCEPOD AKI guidance prior to discharge	
• *Review the individual's medication, including the need for changes in route and time of administration*	
• Identify and take full account of the risk associated with discharge	
• *Obtain discharge NEWS or equivalent local track and trigger score*	
• Set out a clear monitoring plan for ward staff to follow on discharge	
• Complete all rehabilitation assessments require on discharge from critical care in line with local policy	
• Communicate appropriately with other MDT members during and following discharge regarding the condition, treatment plans and follow up arrangements: o Outreach services o Bed management teams/systems o Patient diary follow up teams	
• *Provide discharge information and support to the individual and significant others*	
• Identify the individual's discharge destination and assess the available resources in line with the individual's needs	
• Organise any necessary medications, equipment and rehabilitation aids	
• Identify any reasons for delay in discharge and initiate any actions you can to resolve the problem	
• Record, monitor and escalate the following through the appropriate department in line with local policy: o Delayed discharge o Discharges out of hours o Privacy & Dignity/Single Sex breaches	

1:10 End of Life Care

The following competency statements are about End of Life care requirements for patients within the critical care environment.

1:10.1 End of Life Requirements

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Current national and local policies, protocols and guidelines in relation to End of Life care: o Capacity, care planning and advance care planning in life limiting illness o End of Life Care Strategy o Leadership Alliance for the care of the Dying People: Engagement with patients, families, carers and professionals. o Gold Standard Framework o Preferred Priorities of Care	

1:10.2 Assessment, Decision Making and Initiation of an End of Life Care Plan

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Ethical dilemmas in caring for the critically ill patient nearing the end of life including organ and tissue donation	
• Concept of futility and prolonging life	
• Legal definitions of death	
• Stages a patient may pass through within the dying process	
• Application of clinical decision making models within the critical care setting	
• Role of the broader MDT in End of Life care: o Palliative Care Team o Bereavement Support o Pastoral Care o Specialist Organ Donation Nurse	
• Treatment algorithms as part of individualised End of Life Care planning o Pain o Nausea o Agitation o Dyspnoea o Respiratory Tract Secretions	
• Rapid discharge policies	
• Understand the benefits of organ and tissue donation for both donor families and recipients	

1:10.2 Assessment, Decision Making and Initiation of an End of Life Care Plan continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• *Provide emotional reassurance and support*	
• Agree with patients/relatives and/or significant others the End of Life plan of care	
• Effectively communicate with patient and family throughout the end of life stages, refer to competency Step 1:13.2 and Step 1:13.3	
• Identify any resources required	
• Identify potential problems that can arise as individuals progress towards their End of Life	
• Implement aspects of the individualised End of Life care and treatment plan promptly, in the correct sequence, and at the earliest possible opportunity, so as to achieve the best outcome for the individual	
• Demonstrate an understanding of the emotional and spiritual support the patient and family may require	
• Ensure the safety of individuals as they progress towards their end of life	
• Take prompt and effective action when there is deviation from the agreed care plan	
• Where appropriate implement rapid discharge policies to the patients or relatives preferred place of care	
• Review individualised care and treatment plans and update as necessary	
• Ensure death is certified by an appropriately trained professional	
• Demonstrate understanding of the families religious and spiritual needs immediately following death (including but not limited to): *o Assemble all relevant equipment and assisting with last offices* o Relatives/carer time spend at the bedside *o Respect for privacy*	
• Following the death of a patient, facilitate processes after death (including but not limited to): o Collection of death certificate and patient property o Provision of support documents o Discussions with regards to tissue and/or organ donation	

1.11 Intra & Inter Hospital Transfer

The following competency statement is about the effective coordination and management of intra & Inter hospital transfers for critically ill patients, it includes those individuals who require emergency transport to a different location for investigation, treatment, intervention or on-going care

1:11.1 Assisting in the preparation and transfer of the critically ill

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Your role in the intra & inter hospital transfer of a critically ill patient	
• Indications for transfer from critical care	
• Expected sequence of events	
• Importance and implications of time critical transfers	
• Transfer process including the different considerations for transfer decisions: o Responsibility of care during transfer o Identification of correct patient o Consent o NMC Code of conduct o Competency and skills of transferring personnel o Physiological assessment and optimisation pre transfer o Patient history, treatments and diagnostic tests o Competency and skills of transferring personnel o Risk assessment of patient physiological requirements and maintenance of homeostasis during transit o Infection status o Calibration of appropriate equipment	
• Emergency equipment and transfer bag	
• Contingency planning/back up considerations	
• Drug administration during transfer	
• Documentation and audit	
• Methods, procedures and techniques for the portable monitoring and the types of equipment required during transfer (outline the calibration requirements and battery life expectancy/expiry date of each): o Mechanical Ventilator o Oxygen supply (including flow rates and journey time) o Vital signs monitor o Invasive lines o Infusion devices/syringe pumps o Suction equipment o Transfer bag o Spinal board	
• Implications of standardised monitoring techniques and explain the necessity/appropriateness of each during transfer: o Continuous ECG o Arterial blood pressure versus non -invasive blood pressure o SpO2 o Continuous capnography with wave form analysis o CVP o Temperature	

1:11.1 Assisting in the preparation and transfer of the critically ill continued

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Emergency situations that may arise on transfer: o Airway management o Alternative ventilation methods o Alternative monitoring techniques (non-invasive methods) o Basic and advanced life support o Interpretation of vital signs o Alteration of treatment plans to maintain homeostasis o Titration of medications to optimise condition	
• Process for preparing to transfer the critically ill patient: o Contents of the local emergency/transfer bag and identify the situations in which it may be required o Pharmacology requirements of the patient being transferred o Pre preparation considerations required for drug administration during transfer o Process and sequence of communication required prior to, during and following transfer o Safe moving and handling of the individual and equipment being transferred o Needs of family for information about transfer	
• Documentation that needs to be completed for intra & inter hospital transfer: o Transfer form o Physiological observation chart o Nursing evaluation o Reporting of clinical incidents o Audit tool	
You must be able to undertake the following in a safe and professional manner:	
• Assist in the physiological optimisation/stabilisation of the patient prior to transfer	
• Assist in the preparation of equipment and resources: o Airway management o Portable ventilation o Suction equipment o CV support o Vital sign monitoring o Fluid therapy & pharmacological requirements o Infusion devices/syringe drivers o Transfer bag o Psychological support	
• Assist in the location, calibration and safely set up monitoring and transfer equipment including: o Alarm parameters o Prepare electromechanical devices o Supplementary gases o Transportation o Establishing optimum level of stability on portable equipment prior to transfer	
• Assist in and maintain the safety and continued treatment of the critically ill patient during transfer	
• Assist in the care for the family of the patient being transferred	

1:12 Rehabilitation

The following competency statements are about the initial rehabilitation needs of the patient in a critical care environment, including those that have suffered a major trauma.

1:12.1 Rehabilitation Initial Assessment and Referral

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Relevant national guidance, policies and procedures relating to the rehabilitation needs of the critically ill: o NICE CG 83 o Trauma rehabilitation pathways o NICE CG 50	
• The importance of rehabilitation being identified and started within 24 hours of admission to critical care	
• The importance of Rehabilitation prescription and/or plans	
• How you would identify those critical care patients who may have rehabilitation needs and the resources available to you to highlight such needs: o Rehabilitation pathways *o Short clinical rehabilitation assessments* o Nutritional assessment tools o Swallowing assessments o Pain assessment tools o Delirium assessments o Referral to relevant MDT members o Long term rehabilitation assessments o Rehabilitation goal setting o On-going reassessments of needs	
• Rehabilitation requirements of a critical care patient and the services from which you may require advice or input (including but not limited to): o Pharmacy o Dietician o Physiotherapy o Occupational Therapy o Speech & Language o Clinical psychology	
• Criteria for referral for each MDT member listed in the rehabilitation process	
• Importance of regularly reviewing and screening the rehabilitation needs of the patient	
• Other equipment and resources that may benefit critical care patients with rehabilitation needs (including but not limited to): o Patient diaries o Mobility aids to promote independence o Communication aids o Family presence o Music therapy o Aromatherapy o Massage o Sleep therapy	

1:12.1 Rehabilitation Initial Assessment and Referral continued

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Environment factors in critical care that may impact on rehabilitation needs: o Noise/alarms o Equipment o Level of activity o Disturbance for observation and care needs o Invasive treatments/devices o Isolation	
• Importance of the rehabilitation record and documentation being held separately from the case notes: o Patient needs access to documents o Needs to be transferable between services and wards o Other services further down the pathway need to be able to review a systematic and logical account of the patients journey	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• Instigate a short rehabilitation clinical assessment within 24 hours of admission	
• Instigate a rehabilitation prescription or plan within 24 hours of admission	
• Identify all AHP support required for the patient	
• Make timely referrals to all required MTD members	
• Complete any nurse led assessments require in the first 24 hours: o Nutritional assessment o Delirium assessment	
• Instigate and follow any planned therapy prescribed or recommended by the MDT members involved in the patients rehabilitation journey	
• Reassess the patients rehabilitation needs in line with local policy	
• Measure the patients progress against set goals and feedback this progress to the relevant AHP groups	
• Take an active role in the coordination of the patients rehabilitation pathway	
• Reduce (where possible) the critical care environmental effects on the patient	
• Communicate rehabilitation needs and goals to the patient and their families in a clear and concise manner	
• Involve the patient and significant others in the rehabilitation process as appropriate and able	
• Identify when a condition may impact on the patients and families pre-admission lifestyle and offer support and motivation accordingly	

1:13 Communication & Teamwork

The following competency statements are about communicating effectively with individuals in the critical care environment, you will be expected to communicate effectively with a number of people in a variety of ways and in differing situations.

1:13.1 Communicating with Critical Care Patients

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *The importance of:* *o Focusing on the individual* *o Personal space and positioning when communicating* *o Body language and eye contact when communicating* *o Using the individual's preferred means of communication and language* *o Checking that you and the individuals understand each other* *o Adapting your communication skills to aid understanding* *o Active listening* *o Medications* *o Past medical history* *o Learning disability*	
• The difficulties that can arise with communication in the critical care environment: o Unconscious patient o Artificial airways o Disorientation o Confusion o Delirium o Withdrawal from communication o Addictions o Hallucinations o Sleep deprived patients	
• Methods and ways of communicating that allow for communication difficulties to be overcome (including but not limited to): o Nonverbal communication aids, such as picture boards, writing and electric devices	
• Support equality and diversity	
• The difficulties that may be experience in recognising and interpreting the patient's nonverbal communication (including but not limited to): o Signs of distress o Deterioration in patient understanding o Changes in mental capacity	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Communicate clearly taking into account the needs of the patient	
• Select the most appropriate method of communication for the patient	
• Identify any communication barriers with the individual and take the appropriate action to overcome these: *o Appropriate language & terminology* *o Patients usual communication aids*	
• Provide adequate pain relief	
• Optimise sedation score	
• Relief of any anxiety & stress	

1:13.1 Communicating with Critical Care Patients continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Adopt any communicate aids that are appropriate to the patient's needs: o Glasses o Hearing aids o Picture boards o White boards o Speaking valves o Interpreter o Electronic devices	
• Adapt your communication style to suit the situation & the patients' needs	
• Ensure that the environment for communication is as conducive as possible for effective communication	
• Clarify points to check that the patient understands what is being communicated	
• Actively listen and respond appropriately to any questions and concerns raised during communication with the critical care patient	
• Ensure written documentation reflects the needs of the patient and records any communication that has taken place	

1:13.2 Communicating and Team Working

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Importance of effective team working in critical care (Including but not limited to):* o Efficient and timely completion of workload o Working collaboratively o Achieving common goals o Team satisfaction o Supporting and valuing each other	
• Members of the extended MDT and the main roles and responsibilities of each in caring for the critically ill (including but not limited to): o Critical care doctors o Parental team doctors o Critical care nursing team o Critical care technicians o Specialist nurse o Physiotherapist o Dietician o Pharmacist o Occupational therapist o Speech & Language o Psychologist	
• Importance of referring or responding promptly and appropriately to each member of the MDT	
• Most effective and efficient way to communicate with the appropriate team member *o Emergency call* *o Verbal referral* *o Written referral* *o Fax* *o Appropriate documentation*	
• Identify when a difficulty or problem arises with a MDT member	
• Strategies and mechanisms for positively resolving difficulties	
• Principles of confidentiality, security and sharing of information about critical care patients	
• How your communication skills reflects on you and your team	

1:13.2 Communicating and Team Working continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Work as an effective critical care team member	
• Refer as appropriate to other MDT members of the team	
• Communicate information about your critical care patient in a logical and systematic manner	
• Maintain confidentiality as appropriate to do so	
• Acknowledge and respond to communication promptly	
• Assist and support other team members	
• Deliver shift goals as set by the team leader	
• Focus all your actions on the safety of yourself, your patient and on other team members	
• Actively participate in the professional development of other team members	
• Records and documents any referral, actions and outcomes agreed by the team members	

1:13.3 Communicating in Difficult Situations

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Management of emotional distress in patients, families and colleagues	
• Possible impact of all aspects of significant news on the patients and families well-being	
• Range of communication difficulties and resources available to aid communication	
• Importance of clear and direct communication	
• Importance of the individual's choice	
• Importance of establishing rapport	
• How to ask questions, listen carefully and summarise back	
• Importance of encouraging individuals and families to ask questions	
• How to negotiate effectively with individuals, families and other professionals	
• How to manage own feelings and behaviour when communicating with patients and families	
• Importance of working within your own sphere of competence and seeking advice when faced with situations outside this situation	

1:13.3 Communicating in Difficult Situations continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Provide emotional reassurance and support	
• Maintain a professional attitude when participating in difficult discussions	
• Choose or create an appropriate environment	
• Communicate with individuals and their families/ significant others at a pace and level appropriate to their understanding	
• Review the individual's notes and all supporting information and consult with colleagues so that you clearly understand the individual's current situation prior to the discussion	
• Make the patient and family aware of the purpose of the communication session	
• Explore the individual's perceptions and feelings about the current situation	
• Use questions to assess what information the individual wants to know	
• Provide open and honest information to patients and families at an appropriate level and pace	
• Establish the patient and families understanding of any information provided	
• Summarise the information using different words, phrases or expressions to assist the individuals understanding	
• Provide opportunities for the patient and family to ask questions and express their concerns and emotions	
• Discuss options with the individual and agree the next steps	
• Record the consultation and any agreed outcomes according to National and local policies	

1:14 Infection Prevention & Control

This competency is about developing knowledge, understanding and skills to contribute to Infection Prevention and Control in critical care.

1:14.1 Infection Prevention & Control

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Chain of infection	
• Infection process	
• Alert organisms and conditions	
• Body defence mechanisms	
• Specifically in relation to the critical care environment (including but not limited to) those micro-organisms associated with: o Ventilator Associated Pneumonias (VAPs) o Influenza o Catheter Related Blood Stream Infections (CRBSIs) o MRSA o Clostridium Difficile o VRE o CPE	
• Significance of microbiological results in line with other pathology results and the overall patient condition	
• Key legislation, national guidance outcomes/indicators related to the prevention and control of infection in the critical care environment: o Recent Health and Social Care Act o Communicable disease control o Prevention and management of injuries (including sharps) o Waste management o Safe water management o Decontamination of equipment used for diagnosis and treatment, inclusive of traceability of reusable medical devices o Environmental cleaning o Antimicrobial prescribing & stewardship	
• Effective engagement methods with patients, families/carers and visitors about their needs and priorities in relation to infection prevention and control	
• Effectiveness of existing policies and practices and identify possible areas for improvement	
• Feedback and reporting mechanisms associated with infection prevention and control issues	
• Ensure that suitable and sufficient communication of information on patients' infection status is provided, utilising guidance from the IPC Team: o On admission, discharge and transfer from one health care area or organisation to another o Between health care workers, including displaying appropriate signage o To patients, relatives & visitors with provision of consistent and accurate information supported with appropriate information leaflets	
You must be able to undertake the following in a safe and professional manner:	
• Provide emotional reassurance and support	
• Ensure that suitable and sufficient communication of information on patients' infection status is provided, utilising guidance from the Infection Prevention and Control Team	
• Demonstrate effective and appropriate use of personal and protective equipment in minimising the risk of infection spread, on admission, discharge and transfer: o Between health care workers, including displaying appropriate signage o To patients, relatives & visitors with provision of consistent and accurate information supported with appropriate information leaflets	

1:14.1 Infection Prevention & Control continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• *Demonstrate best practice in the care of patients' requiring:* *o Source Isolation* *o Protective isolation*	
• Understanding of local surveillance, outbreak or incident information and how this would be communicated to the team	
• *Demonstrate best practice in environmental tidiness & cleanliness (including but not limited to):* *o Appropriate level of cleaning to instigate on patient discharge* *o Cleaning and disinfection of items that come into contact with the patient and/or their environment that are not invasive (e.g. beds, commodes, hoists)*	
• *Safe disposal of waste (including sharps and linen)*	
• *Safe storage of food and medical equipment*	
• *Bedside damp dusting regime*	
• Demonstrate best practice in decontamination of reusable medical devices, following manufacturer guidance and local policy related to: o Processes for cleaning, disinfection, sterilisation o Specifically but not limited to decontamination of: o Ventilators/Infusion pumps o Renal Replacement Therapy (RRT) machines o Humidification equipment o Endoscopic equipment, such as bronchoscopes o Diagnostic equipment	
• Demonstrates best practice in the use of disposable medical devices, following manufacturer guidance and local policy, applying knowledge of 'single use' and 'single patient use'	
• Demonstrates best practice in obtaining, packaging, handling, labelling and transport of biological samples, with reference to local pathology guidance	
• *Demonstrates safe management of invasive devices and applies safe practices to prevent device related infections*	
• Participates in audit and surveillance activities (including but not limited to): o Department of Health, Saving Lives High Impact Intervention (HII) o Care bundle audits o Environmental cleanliness audits	
• Aware of local statistics on the prevalence of alert organisms, outbreaks, serious untoward incidents and action plans to deal with occurrences of infection, including where applicable the results of root cause analyses and action plans	
• Acts upon any risks identified and communicates them effectively to the appropriate people	
• Ensures that patients who develop an infection are identified promptly and receive appropriate treatment to prevent the risk of cross contamination (including but not limited to): o Recognition of the signs and management of infection & sepsis o Safe practice in administration of antimicrobial drugs, with reference to local formulary o Safe practice in administration of blood and blood products, with reference to local policies/guidance	
• *Takes appropriate actions to escalate concerns when safety and quality are compromised*	
• Continuously assess and monitor the risk to safety and quality and challenge others actions and decisions when they put individuals or the team at risk	
• *Ensure safe practice in the event of occupational exposure*	

1:15 Evidenced Based Practice

The following competency statement is about applying evidence based practice to the activities you undertake in critical care, it also includes audit conducted within the critical care setting and the importance of benchmarking against evidence based quality standards.

1:15.1 Evidenced Based Practice

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Undertaking a literature search	
• Managing the quantity of literature you find	
• Investigating the grade of evidence found	
• Critiquing research evidence	
• Investigating the validity & reliability of any studies	
• Formulating opinion regarding practice	
• Offering recommendations for alterations/changes to practice based on your findings	
• How you integrate evidence based practice into your daily work	
• Importance of keeping up to date with developments and new resources relevant to critical care	
• Key professional and critical care resources that are available to you to ensure you are abreast of any developments	
• Any recent trends and developments within critical care that impact on the quality of patient care and service delivery	
• Importance of conducting benchmarking exercises against the following quality standards to demonstrate local compliance: o Care Bundles o NICE guidance o ICS guidance o NPSA guidance o High Impact Interventions	
• CCMDS data collection and its relevance within critical care delivery: o Elements of the mandatory data set o Time it should be completed o Definitions of organ support o Accurate completion o Consequence of inaccurate or incomplete data collection	
• ICNARC data collection and its relevance within critical care delivery: o Accurate completion o Definitions and criteria o Reasons for participating o Importance of the data analysis o Ways in which the data can be used locally o Consequences of inaccurate or incomplete data collection	

1:15.1 Evidenced Based Practice continued

You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Apply existing local, regional and national guidance to your practice	
• Keep abreast of changing in critical care practice	
• Outline recent trends and developments in critical care	
• Complete required benchmarking exercises accurately and in the time frame outlined	
• Complete the CCMDS data set accurately and at the correct time of day	
• Complete all sections of the ICNARC data set correctly and in the time frames	
• Conduct a small literature review in relation to one area of your practice, critique the literature found and offer recommendations and suggestions for practice changes base on the reviewed evidence	

1:16 Professionalism

The following competency statement is about maintaining professionalism in critical care nursing practice

1:16.1 Maintaining Professionalism

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• NMC code (2015) Professional standards of practice and behaviour for nurses and midwives	
You must be able to undertake the following in a safe and professional manner:	
• Prioritise people: *o Treat people as individuals and uphold their dignity* *o Listen to people and respond to their preferences and concerns* *o Make sure that peoples physical, social and psychological needs are assessed and responded to* *o Act in the best interests of people at all times* *o Respect people's right to privacy and confidentiality*	
• Practice Effectively: *o Practice in line with the best available evidence* *o Communicate clearly* *o Work collaboratively* *o Share your, skills, knowledge and experience with colleagues for the benefit of people receiving care* *o Keep clear and accurate records relevant to your practice* *o Be accountable for your decisions to delegated tasks and duties*	
• Preserve Safety: *o Recognise and work within the limits of your competence* *o Be open and candid with all service users about aspects of care and treatment, including where mistakes or harm have occurred* *o Offer help if an emergency arises (practice setting or elsewhere)* *o Act without delay if you believe there is a risk to patient safety or public protection* *o Raise concerns immediately if you believe that there is a vulnerable person at risk* *o Reduce (as far as possible) any potential for harm associated with your practice*	
• Promote Professionalism & Trust: *o Uphold the reputation of your profession at all times* *o Respond to any compliant* *o Provide leadership to make sure peoples wellbeing is protected and to improve their experience of the healthcare system*	

1:17 Defensible Documentation

This competency statement is about the legal and accountable aspects of documentation within the critical care environment.

1.52 Documentation

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• The impact of the NMC record keeping guidance (2009) on the registered nurses legal responsibility in written documentation: o Clear *o Accurate* *o Purposeful* *o Contemporaneous* *o Author of entry – printed, signed and professional PIN number*	
• Your accountability in relation to: o Statute law o Case law o Civil law o Criminal law	
• The reasons for accessing and maintaining health care records: o Helping to improve accountability o Showing how decisions related to patient care were made o Supporting the delivery of services o Supporting effective clinical judgements and decisions o Supporting patient care and communications o Making continuity of care easier o Providing documentary evidence of services delivered o Promoting better communication and sharing of information between members of the multi-professional healthcare team, patients and families o Helping to identify risks, and enabling early detection of complications o Supporting clinical audit, research, allocation of resources and performance planning o Helping to address complaints or legal processes	
• Your responsibility in relation to maintaining health care records o Use of electronic tracking systems for health care records o Privacy and confidentiality of patient information o Caldecott guidelines	
You must be able to undertake the following in a safe and professional manner:	Competency Fully Achieved Date/Sign
• Complete an accurate admission profile of your patient	
• Provide an accurate, concise, timely and contemporaneous record of your patient's treatment and events, utilising appropriate systems as required	
• Maintain an accurate, concise, timely and contemporaneous record of communication between the MDT and patient and relatives	
• Complete the necessary care plans, risk assessments and evaluations	
• Accurately file patient information utilising the health care records systems in place	

1:18 Mental Capacity

This competency statement is about the management of those patients who may have diminished mental capacity within the critical care setting

1:18.1 Mental Capacity & Safe Guarding Adults

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• Mental Capacity Legislation specifically: o The definition of 'capacity' o Key principles of the legislation and their relevance to the critical care patient o Definition of a 'vulnerable adult' or 'adult at risk' o Groups of people covered by the legislation o Meaning of 'best interests' o Issues surrounding consent in critical care o Types of abuse o Indicators of abuse o How to report concerns about possible abuse, including knowledge of safeguarding leads within your local Trust	
• Code of Practice and the role of the critical care nurse involved in decision making processes on behalf of adults who lack capacity	
• Deprivation of Liberty safeguards - Code of Practice for those individuals who lack the capacity to consent to treatment or care	
• Strategies and tools available for assessing and recording mental capacity	
• Procedures available for referral of patients presenting with diminished mental capacity	
• Implications of diminished mental capacity for critical care practice and in emergency situations	
• Role and principles of the nurse as a patient advocate	
• Lasting Power of Attorney and Court Appointed Deputy	
• Advance decisions	
• Provide evidence of completion of local mandatory training in relation to mental capacity and safeguarding issues	
You must be able to undertake the following in a safe and professional manner:	
• Acknowledge limitations of competence in relation to mental capacity and Safe Guarding Adults management with reference to: o NMC Professional Standards (2015)	
• Demonstrate practices that ensure safety for self, patient and colleagues	
• Minimise potential sources of harm to the vulnerable individual	
• Risk assessments & reporting procedures, including application of the two stage mental capacity assessment	
• Make appropriate Deprivation of Liberty applications	
• Local guidelines/policies related to Health, Safety & Security	
• Demonstrate effective communication measures with the patient, families and/or carers and the wider MDT members, on issues related to diminished mental capacity Range of strategies may include: o Handover o Team meetings o Written records	

1:19 Leadership

The following competency statements are about developing leadership styles and skills throughout your professional development in critical care.

1:19.1 Demonstrating Personal Qualities

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Self awareness*	
• *Managing yourself*	
• *Continuing professional development*	
• *Acting with integrity*	
You must be able to undertake the following in a safe and professional manner:	
• Prioritise tasks and duties effectively for self and others	
• Identify and reflect on your own behaviour	
• Identify and reflect on personal strengths and weaknesses	
• Effectively fulfil your role	
• Maintain routine critical care practice	
• *Maintain Health & Safety*	
• *Recognise personal stress*	
• Manage time constructively	
• Recognise stress in other critical care team members	
• Use feedback to improve performance	
• Set own achievable development goals	
• *Make effective use of learning opportunities*	
• Use reflection to learn from previous experiences	
• Apply ethical issues, debates and principles to your practice	
• Recognise when ethical issues may conflict with your personal views	
• Effectively communicate with patients, families and multi professional team members, refer to competency Step 1:13.1, 1:13.2 and 1:13.3	

1:19.2 Working with Others

You must be able to demonstrate through discussion essential knowledge of (and its application to your supervised practice):	Competency Fully Achieved Date/Sign
• *Developing networks with the multidisciplinary team*	
• Building and maintaining relationships	
• Encouraging contributions of others	
• Working within teams, refer to competency Step 1:13.2	
You must be able to undertake the following in a safe and professional manner:	
• *Provide emotional reassurance and support*	
• *Care for the critical care patient as part of the MDT*	
• Involve other relevant team members in problem solving and decision making	
• Participate in MDT meetings	
• Support peer group	
• Build effective relationships and rapport with team members through good communication skills and dealing effectively with communication challenges	
• Recognise and value others	
• Challenge constructively when your view point differs to others	
• Effectively work with a diverse team regardless of social, educational, cultural and sexual orientation differences	
• Encourage others to develop leadership skills	

Assessment, Development & Revalidation Record Summary

Date	Assessment Completed	Lead Assessor Signature

Assessment, Development & Revalidation Record Summary continued

Date	Assessment Completed	Lead Assessor Signature

Initial Assessment & Development Plan

Date | | | (Please add date to the Assessment Record Summary)

This meeting between Learner and Lead Assessor should take place during induction. It is to identify the learning needs of the nurse during their supernumerary period and identify those competencies that should be attained within the first 3 months of the development programme.

CURRENT CRITICAL CARE KNOWLEDGE, UNDERSTANDING AND SKILLS

COMPETENCIES TO BE ACHIEVED

SPECIFIC SUPPORTIVE STRATEGIES REQUIRED

Learners Signature: .....

Lead Assessors / Practice Educators Signature: .....

NEXT AGREED MEETING DATE: | | |

Ongoing Assessment & Development Plan

Date | | | (Please add date to the Assessment Record Summary)

This meeting between Learner and Lead Assessor is to identify the progress made by the nurse in achieving the competencies identified in the initial and/or previous meetings. It is here further objectives will be set. On-going assessments should take place at least every 3 months. If the learner requires additional support a further action plan can be completed.

REVIEW OF COMPETENCIES ACHIEVED

ON TARGET: YES ☐ NO ☐

IF NOT WHICH COMPETENCIES HAVE YET TO BE MET

REASONS FOR NOT ACHIEVING

SPECIFIC OBJECTIVES TO ACHIEVE COMPETENCE

KEY AREAS & ADDITIONAL COMPETENCIES TO BE ACHIEVED BEFORE NEXT MEETING

Learners Signature: .....

Lead Assessors / Practice Educators Signature: .....

NEXT AGREED MEETING DATE: | | |

Additional Action Planning

Date | | |

This document is to be completed as required to set SMART objectives for the learner who requires additional support to achieve certain competencies (these will have been identified during the 3 monthly Ongoing Assessment & Development plan).

AREAS FOR FURTHER ACTION PLANNING

Learners Signature: .....

Lead Assessors / Practice Educators Signature: .....

NEXT AGREED MEETING DATE: | | |

Step 1 - Final Competency Assessment

Date | | | (Please add date to the Assessment Record Summary)

This meeting is to identify that all the competencies within Step 1 have been achieved and that the nurse is considered a safe competent practitioner

COMPETENCY STATEMENT:
The nurse has been assessed against the competencies within this document and measured against the definition of competence below by critical care colleagues, mentors and assessors and is considered a competent safe practitioner within the critical care environment:

"The combination of skills, knowledge and attitudes, values and technical abilities that underpin safe and effective critical care nursing care and interventions".

As part of quality assurance the nurse is expected to maintain a portfolio of practice as part of NMC regulations and revalidation to support on-going competence and declare any training and/or development needs to their line manager or appropriated other.

Competency will be reviewed annually as part of staff personal development plans and evidence of this will be required for NMC revalidation. Where necessary objectives will be set to further develop any emerging competency required to work safely within the critical care environment.

LEAD ASSESSORS COMMENTS

LEARNERS COMMENTS

Learners Signature: .....

Lead Assessors / Practice Educators Signature: .....

NEXT AGREED MEETING DATE: | | |

Annual Competency Review (to accompany local appraisal documentation)

Date | | | (Please add date to the Assessment Record Summary)

This record is a statement between the nurse who has completed Step 1 competencies successfully and their Appraiser. It should be used alongside local appraisal systems annually to ensure that the nurse continues to demonstrate themselves as a safe competent critical care practitioner

OVERALL COMPETENCY MAINTAINED YES ☐ NO ☐

IF NOT WHICH COMPETENCIES REQUIRE FURTHER DEVELOPMENT

SPECIFIC OBJECTIVES TO ACHIEVE COMPETENCE

FURTHER COMMENTS

Signature: .....

Lead Assessors / Practice Educators Signature: .....

NEXT AGREED MEETING DATE: | | |

NMC Revalidation Checklist (every 3 years)

Date | | | (Please add date to the Assessment Record Summary)

Revalidation is a continuous process that nurses need to engage with throughout their career. It is not a point in time activity or assessment; however, you will need to be able to provide evidence of achievement against the NMC requirements. This document should be completed as part of your local appraisal.

EVIDENCE OF COMPLETING 450 PRACTICE HOURS IN CRITICAL CARE YES ☐ NO ☐

LIST EVIDENCE PRODUCED BELOW

EVIDENCE OF COMPLETING 40 HOURS CONTINOUS PROFESSIONAL DEVELOPMENT (CPD) YES ☐ NO ☐

(20 HOURS NEED TO BE PARTICIPATORY LEARNING, LIST EVIDENCE PRODUCED BELOW)

EVIDENCE OF 5 REFELECTIIONS YES ☐ NO ☐

LIST EVIDENCE PRODUCED BELOW

EVIDENCE OF APPROPRIATE PROFESSIONAL INDEMNITY ARRANGEMENTS YES ☐ NO ☐

LIST EVIDENCE PRODUCED BELOW

NMC Revalidation Checklist continued

3rd PARTY CONFIRMATION

LEARNER	CONFIRMER
LEARNERS NAME	CONFIRMERS NAME
LEARNERS SIGNATURE	CONFIRMERS SIGNATURE
LEARNERS JOB TITLE	CONFIRMERS JOB TITLE
LEARNERS PIN	CONFIRMERS PIN
LEARNERS E MAIL ADDRESS	CONFIRMERS E MAIL ADDRESS

Reflective Accounts to inform NMC Revalidation

You are required to record a minimum of five written reflections on the NMC Code (2015) and your Continuous Professional Development as well as gaining practice-related feedback, as outlined in 'How to revalidate with the NMC'.

You are advised to complete the following documents during your critical care development to inform your NMC Revalidation, you are required to discuss these reflections with your Mentor/Lead Assessor and/or Practice Educator at your on-going assessment reviews, your final assessment and/or your annual progress review as part of your local appraisal process. Once you have discussed these reflections your Mentor/Lead Assessor and/or Practice Educator will need to complete the relevant 'Professional Development Discussions' (PDD) documentation to provide evidence of this.

Reflective Account

Date | |

Please fill in a page for each of your reflections, ensuring you do not include any information that might identify a specific patient or service user. You must discuss these reflections as part of a professional development discussion (PDD) with another NMC registrant who will need to complete the PDD document to provide evidence of this taking place.

WHAT WAS THE NATURE OF THE CPD ACTIVITY/ PRACTICE-RELATED FEEDBACK?

WHAT DID YOU LEARN FROM THE CPD ACTIVITY AND/OR FEEDBACK?

HOW DID YOU CHANGE OR IMPROVE YOUR WORK AS A RESULT?

HOW IS THIS RELEVANT TO THE CODE?
(Select a theme, Prioritise people - Practice effectively - Preserve safety - Promote professionalism and trust)

Signature:

Professional Development Discussion (PDD)

Date | | |

You are required to have a PDD with another NMC registrant covering your written reflections on the Code, your CPD and practice-related feedback. This form should be completed by the registrant (Mentor/Lead Assessor and/or Practice Educator) with whom you have had the discussion.

NAME NMC PIN

EMAIL ADDRESS

PROFESSIONAL ADDRESS (INCLUDING POSTCODE)

NAME OF REGISTRANT WITH WHOM YOU HAD A PDD DISCUSSION

NMC PIN OF REGISTRANT WITH WHOM YOU HAD A PDD DISCUSSION

NUMBER OF REFLECTIONS DISCUSSED:

DECLARATION: I CONFIRM THAT I HAVE DISCUSSED THE NUMBER OF REFLECTIVE ACCOUNTS LISTED ABOVE, WITH THE ABOVE NAMED REGISTRANT, AS PART OF A PDD

Signature:

Abbreviations

A,B,C,D,E	Airway, Breathing, Circulation, Disability, Exposure
ABG	Arterial Blood Gas
ADH	Anti-Diuretic Hormone
AHP	Allied Health Care Professional
AKI	Acute Kidney Injury
ALI	Acute Lung Injury
ALS	Advanced Life Support
ANTT	Aseptic Non Touch Technique
ARDS	Acute Respiratory Distress Syndrome
AVPU	Alert, Voice, Pain, Unresponsive
BACCN	British Association of critical Care Nurses
BLS	Basic Life Support
BNF	British National Formulary
BP	Blood Pressure
BTS	British Thoracic Society
CAM-ICU	Confusion Assessment Method
CC3N	Critical Care Networks National Nurse Lead Group
CCMDS	Critical Care Minimum Data Set
C-Diff	Clostridium difficile
CMS	Capacity Management System
CO	Cardiac Output
CO2	Carbon Dioxide
COPD	Chronic Obstructive Pulmonary Disease
COSHH	Control of Substances Hazardous to Health
CPAP	Continuous Positive Airway Pressure
CPD	Continuing Professional Development
CPE	Carbapenemase Producing Enterobacteriaceae
CPP	Cerebral Perfusion Pressure
CRBSI	Catheter Related Blood Stream Infection
CSF	Cerebrospinal Fluid
CT	Computerised Tomography
CV	Cardiovascular
CVP	Central Venous Pressure
CVVH	Continuous Veno Venous Haemofiltration
CVVDH	Continuous Veno Venous Dialysis
CVVHDF	Continuous Veno Venous Haemodiafiltration
CXR	Chest X-Ray
DBD	Donation following Brain Death
DCD	Donation following Circulatory Death
DOH	Department of Health
DOS	Directory of Service
ECG	Electrocardiograph
EPUAP	European Pressure Ulcer Advisory Panel
ET	Endotracheal
EtCO2	End Tidal Carbon Dioxide
ETT	Endotracheal Tube
GCS	Glasgow Coma Scale
GI	Gastrointestinal
H2 Antagonist	Histamine H2-receptor antagonists
HEI	Higher Educational Institute
HII	High Impact Intervention
HME	Heat Moisture Exchange
HR	Heart Rate
ICNARC	Intensive Care National Audit & Research Centre
ICP	Intracranial Pressure
ICS	Intensive Care Society
ICU	Intensive Care Unit
I:E Ratio	Inspiratory : Expiratory Ratio
IHD	Intermittent Haemo Dialysis
ILS	Intermediate Life Support
IPC	Infection Prevention & Control
IRV	Inverse Ration Ventilation
IV	Intravenous
JVP	Jugular Venous Pressure
KSF	Knowledge & Skills Framework
MAP	Mean Arterial Pressure
MDT	Multidisciplinary Team
MEDUSA	Injectable Drug Administration Guide
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
MUST	Malnutrition Universal Screen Tool
NEWS	National Early Warning Score
NG	Nasogastric
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NICE CG	National Institute of Clinical Excellence-Clinical Guideline
NIV	Non Invasive Ventilation
NJ	Naso-jejunal
NMC	Nursing & Midwifery Council
NPSA	National Patient Safety Agency
PCA	Patient Controlled Analgesia
PDD	Professional Development Discussion
PEA	Pulseless Electrical Activity
PEG	Percutaneous Endoscopic Gastroscopy
PIN	Personal Identification Number
PPE	Personal Protective Equipment
RCN	Royal College of Nursing
RIG	Radiologically Inserted Gastrostomy
RR	Respiratory Rate
RRT	Renal Replacement Therapy
SAH	Subarachnoid Haemorrhage
SALT	Speech and Language Therapy
SIRS	Systemic Inflammatory Response Syndrome
SLEDD	Sustained Low-Efficiency Dialysis
SMART	Specific, Measurable, Achievable, Realistic, Timely
SNOD	Specialist Organ Donation Nurse
SPO2	Saturated Oxygen
SR	Sinus Rhythm
SVO2	Mixed Venous Oxygen Saturation
SV	Stroke Volume
SVR	Systemic Vascular Resistance
SVT	Sinus Ventricular Tachycardia
TMP	Trans Membrane Pressure
VAP	Ventilator Associated Pneumonia
V/Q	Ventilation / Perfusion
VRE	Vancomycin Resistant Enterococci
VTE	Venous thromboembolism

Learning Resources

BACCN website: www.baccn.org.uk

Brain Trauma Foundation (2007) Guidelines for the management of traumatic brain injury. Journal of Neuro Trauma. 24 (1) pp S- 59 S - 64. p 17-23. p 47-74

Borthwick, M, Bourne, R, Craig, M, Egan, A and Oxley, J (2006) Detection, prevention and treatment of delirium in critically ill patient. United kingdom Clinical Pharmacy association.

CC3N website: www.cc3n.org.uk

Department of Health (1996) Guidelines on admission to and discharge from intensive care and high dependency units. DoH, London

Department of Health (2009) Reference guide to consent for examination or treatment (2nd edition) London: DH

Department of Health (2008).Clean, safe care: Reducing infections and saving lives. Gateway ref: 9278

Department of Health (2010) High Impact Intervention: Renal haemodialysis. DOH guideline.

Department of Health (2012) Health and Social Care Act. March 2012, TSO

EPUAP (2009) European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Treatment of pressure ulcers: Quick Reference Guide. Washington DC: National Pressure Ulcer Advisory Panel

Faculty of Intensive Care Medicine website: www.ficm.ac.uk

ICU Steps website: www.icusteps.org

ICNARC website: www.icnarc.org

Intensive Care Society website: www.ics.ac.uk

Intensive Care Society (2004) Guidelines for Adult Organ and Tissue Donation Prepared on behalf of the Intensive Care Society by the Society's Working Group on Organ and Tissue Donation

Intensive Care Society (2009) Standards and recommendations for the provision of renal replacement therapy on the intensive care unit in the United Kingdom. ICS guideline

Intensive Care Society (2011) Guidelines for the transport of critically ill adults. Standards and Guidelines

National Institute for Clinical Excellence (2007) Head Injury: Triage, Assessment and Early Management of Head Injury in Children, Infants and Adults. www.nice.org.uk/CG056

NCEPOD (2009) Adding Insult to injury: a review of the care of patients who dies in hospital with a primary diagnosis of acute kidney injury (acute renal failure. NICE publication

NHS England website: www.england.nhs.uk

NHS Confederation (2012): The NHS handbook: The essential guide to the new NHS. Available at www.nhsconfed.org

NOrF website: www.norf.org.uk

NMC website: www.nmc.org.uk

RCN website: www.rcn.org.uk

Tortora G. J. and Derrickson B., H. (2011) Principles of Anatomy and Physiology, International Student Version (13th Edition). John Wiley & sons, inc. New York.

UK Code of Practice for the diagnosis of brain stem death; including guidelines for the identification and management of potential organs and tissue donors. Working Party established through the Royal College of Physicians on behalf of the Academy of Medical Royal Colleges (1998)

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CHAIR:

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www.cc3n.org.uk

www.baccn.org.uk

www.ics.ac.uk

www.rcn.org.uk

www.icusteps.org.uk

www.norf.org.uk

www.aiho.org.uk